MANDATED USE OF STATE PRESCRIPTION DRUG MONITORING PROGRAMS (PMPS)

SPECIFIED CIRCUMSTANCES REQUIRING PRESCRIBERS/DISPENSERS TO ACCESS PMP DATA

Research current through November 8, 2016.

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INTRODUCTION

Thirty-four (34) states now specify circumstances in which prescribers, dispensers, or both must access a patient’s PMP prescription history. Texas physicians must consider reviewing a patient’s PMP prescription history prior to prescribing dangerous drugs or controlled substances for the treatment of chronic pain:

ALASKA  MARYLAND  OKLAHOMA
ARIZONA  MASSACHUSETTS  PENNSYLVANIA
ARKANSAS  MINNESOTA  RHODE ISLAND
CALIFORNIA  MISSISSIPPI  TENNESSEE
COLORADO  NEVADA  TEXAS
CONNECTICUT  NEW HAMPSHIRE  UTAH
DELAWARE  NEW JERSEY  VERMONT
GEORGIA  NEW MEXICO  VIRGINIA
INDIANA  NEW YORK  WASHINGTON
KENTUCKY  NORTH CAROLINA  WEST VIRGINIA
LOUISIANA  NORTH DAKOTA  WISCONSIN
MAINE  OHIO

For each of these states, this compilation provides the specific statutory and/or regulatory language that identifies when a prescriber or dispenser has to check the PMP for a patient. Any questions regarding whether and how a state’s language applies to a particular case or situation should be directed to the practitioner’s licensing entity. However, general circumstances in which mandated use may apply include:

- Worker’s compensation.
- Opioid addiction treatment.
- Residential drug and alcohol services program.
- Treatment of non-cancer chronic pain with controlled substances.
- Treatment of obesity with amphetamine/amphetamine anorectic controlled substance.
- Prescribing/dispensing controlled substances.
  - Certain substances: opioids, benzodiazepines, buprenorphine or drug containing buprenorphine, carisoprodol, substance containing hydrocodone or hydrocodone only extended release.
  - Initial prescribing or dispensing of certain substances, e.g, opioids.
  - Set quantity or prescribed for prolonged duration.
  - New controlled substance prescription for new patient.
  - New controlled substance prescription for new course of treatment.
  - Replacement prescription.
- Reason to believe patient wants controlled substance prescription for illegal or medically inappropriate reasons, or may be misusing, abusing or diverting medication
- Professional judgment indicates review necessary to prevent opioid abuse.
- Prescriber violation of law/rule regarding prescription drugs.
- Opioid prescribing improvement program

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ALASKA

§ 17.30.200 (eff. July 17, 2017)
S.B. 74 2016

West’s Alaska Statutes Annotated (2016)
Title 17. Food and Drugs
Chapter 30. Controlled Substances
Article 5. Controlled Substance Prescription Database

§ 17.30.200. Controlled substance prescription database

<Text of Section Effective July 17, 2017>

. . .

(k) In the regulations adopted under this section, the board shall provide

(1) that prescription information in the database shall be purged from the database after two years have elapsed from the date the prescription was dispensed;

(2) a method for an individual to challenge information in the database about the individual that the person believes is incorrect or was incorrectly entered by a dispenser;

(3) a procedure and time frame for registration with the database;

(4) that a practitioner review the information in the database to check a patient’s prescription records before dispensing, prescribing, or administering a schedule II or III controlled substance under federal law to the patient; the regulations must provide that a practitioner is not required to review the information in the database before dispensing, prescribing or administering

(A) a controlled substance to a person who is receiving treatment

(i) in an inpatient setting;

(ii) at the scene of an emergency or in an ambulance; in this sub-subparagraph, “ambulance” has the meaning given in AS 18.08.200;

(iii) in an emergency room;

(iv) immediately before, during, or within the first 48 hours after surgery or a medical procedure;

(v) in a hospice or nursing home that has an in-house pharmacy; or
(B) a nonrefillable prescription of a controlled substance in a quantity intended to last for
not more than three days.

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ARIZONA

§ 23-1062.02
§ 32-1501
§ 36-2606
S.B. 1283 2016

Arizona Revised Statutes Annotated (2016)
Title 23. Labor
Chapter 6. Workers' Compensation
Article 9. Payment of Compensation

§ 23-1062.02. Off-label prescription of controlled substances; prescription of schedule II controlled substances; reports; treatment plans; definition

A. A physician shall include in the report required under commission rule information pertaining to the following:

1. The off-label use of a narcotic, opium based controlled substance or schedule II controlled substance by a claimant.

2. The use of a narcotic or opium based controlled substance or the prescription of a combination of narcotics or opium based controlled substances at or exceeding a one hundred twenty milligram morphine equivalent dose per day.

3. The prescription of a long-acting or controlled release opioid for acute pain.

B. The information required pursuant to subsection A of this section shall include the justification for use of the controlled substance, and a treatment plan that includes a description of measures that the physician will implement to monitor and prevent the development of abuse, dependence, addiction or diversion by the employee. The physician shall include in the treatment plan a medication agreement, a plan for subsequent follow-up visits and random drug testing and documentation that the medication regime is providing relief that is demonstrated by clinically meaningful improvement in function. If the drug test of the employee reveals inconsistent results, the physician within five business days shall provide a written report to the carrier, self-insured employer or commission setting forth a treatment plan to address the inconsistent drug test results.

C. Within two business days of writing or dispensing an initial prescription order for at least a thirty-day supply of an opioid medication for the employee, a physician shall submit an inquiry to the Arizona State Board of Pharmacy requesting the employee’s prescription information that is compiled under the controlled substances prescription monitoring program prescribed in Title 36, Chapter 28. The physician shall report the results to the carrier, self-insured employer or commission as soon as reasonably practicable but no later than thirty days from the date of the inquiry. Thereafter, the carrier, self-insured
employer or commission may request no more than once every two months that the physician perform additional inquiries to the Arizona State Board of Pharmacy.

D. If the result of an inquiry to the Arizona State Board of Pharmacy reveals that the employee is receiving opioids from another undisclosed health care provider, the physician shall within five business days report the results to the carrier, self-insured employer or commission.

E. If the physician does not comply with this section:

1. The carrier, self-insured employer or commission is not responsible for payment for the physician's services until the physician complies with this section.

2. Except for a self-insured employer that provides medical care pursuant to section 23-1070, an employer, carrier or commission may request a change of physician after making a written request to the physician to comply with this section and the request identifies the area of incompliance. If a change of physician is ordered and the order becomes final, the employee shall select a physician whose practice includes pain management and who agrees to comply with this section. If other medical providers are not available in the employee’s area of residence, the employer, carrier or commission shall pay in advance for the employee’s reasonable travel expenses, including the cost of transportation, food, lodging and loss of pay, if applicable.

F. If medically necessary, the carrier, self-insured employer or commission shall provide drug rehabilitation and detoxification treatment for an employee who becomes dependent on or addicted to opioids that are prescribed for a work-related injury. In the event of a medical conflict regarding the necessity for drug rehabilitation and detoxification, the carrier, self-insured employer or commission shall continue to provide the opioids until a determination is made after a hearing by an administrative law judge.

G. If the employee resides out of state, the carrier, self-insured employer or commission may not be responsible for providing medications that are subject to this section if the out-of-state physician fails to comply with this section. If the other state has a controlled substances monitoring program, the physician shall submit an inquiry to the database as prescribed in subsection C of this section.

H. This section does not apply to medications administered to the employee while the employee is receiving inpatient hospital treatment.

I. A carrier, self-insured employer or the commission may require physician compliance with this section notwithstanding the existence of a prior award addressing medical maintenance benefits for medications. A carrier or self-insured employer is not liable for bad faith or unfair claims processing for any act taken in compliance of and consistent with this section.
J. For the purposes of this section:

1. “Clinically meaningful improvement in function” means any of the following:
   (a) A clinically documented improvement in range of motion.
   (b) An increase in the performance of activities of daily living.
   (c) A return to gainful employment.

2. “Inconsistent results” means:
   (a) The employee’s reported medications, including the parent drugs or metabolites, are not detected.
   (b) Controlled substances are detected that are not reported by the employee.

3. “Off-label use” means use of a prescription medication by the physician to treat a condition other than the use for which the drug was approved by the United States food and drug administration.

Arizona Revised Statutes Annotated (2016)
Title 32. Professions and Occupations
Chapter 14. Naturopathic Medicine
Article 1. Naturopathic Physicians Medical Board
§ 32-1501. Definitions

31. “Unprofessional conduct” includes the following, whether occurring in this state or elsewhere:
   (yy) When issuing a written certification as defined in § 36-2801, failing or refusing to include in the adequate medical records of a patient a copy of all of the following:
   (i) The medical records relied on by the physician to support the diagnosis or confirmed diagnosis of the patient’s debilitating medical condition.
   (ii) The written certification.
   (iii) The patient’s profile on the Arizona board of pharmacy controlled substances prescription monitoring program database.
36-2606. Registration; access; renewal; requirements; mandatory use; annual user satisfaction survey; report; definition.

H. Beginning the later of October 1, 2017 or sixty days after the statewide health information exchange has integrated the controlled substances prescription monitoring program data into the exchange, a medical practitioner, before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III or IV for a patient, shall obtain a patient utilization report regarding the patient for the preceding twelve months from the controlled substances prescription monitoring program's central database tracking system at the beginning of each new course of treatment and at least quarterly while that prescription remains a part of the treatment. Each medical practitioner regulatory board shall notify the medical practitioners licensed by that board of the applicable date. A medical practitioner may be granted a one-year waiver from the requirement in this subsection due to technological limitations that are not reasonably within the control of the practitioner or other exceptional circumstances demonstrated by the practitioner, pursuant to a process established by rule by the Arizona state board of pharmacy.

I. The medical practitioner is not required to obtain a patient utilization report from the central database tracking system pursuant to subsection H of this section if any of the following applies:

1. The patient is receiving hospice care or palliative care for a serious or chronic illness.

2. The patient is receiving care for cancer, a cancer-related illness or condition or dialysis treatment.

3. A medical practitioner will administer the controlled substance.

4. The patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility.

5. The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for an invasive medical or dental procedure or a medical or dental procedure that results in acute pain to the patient.

6. The medical practitioner is prescribing the controlled substance to the patient for no more than a ten-day period for a patient who has suffered an acute injury or a medical or dental disease process that is diagnosed in an emergency department setting and that results in acute pain to the patient. An acute injury or medical disease process does not include back pain.

7. The medical practitioner is prescribing no more than a five-day prescription and has reviewed the program's central database tracking system for that patient within the last thirty days, and the system shows that no other prescriber has prescribed a controlled substance in the preceding thirty-day period.
J. If a medical practitioner uses electronic medical records that integrate data from the controlled substances prescription monitoring program, a review of the electronic medical records with the integrated data shall be deemed compliant with the review of the program's central database tracking system as required in subsection H of this section.

K. The board shall promote and enter into data sharing agreements for the purpose of integrating the controlled substances prescription monitoring program into electronic medical records.

L. By complying with this section, a medical practitioner acting in good faith, or the medical practitioner's employer, is not subject to liability or disciplinary action arising solely from either:

1. Requesting or receiving, or failing to request or receive, prescription monitoring data from the program's central database tracking system.

2. Acting or failing to act on the basis of the prescription monitoring data provided by the program's central database tracking system.

M. Notwithstanding any provision of this section to the contrary, medical practitioners and their delegates are not in violation of this section during any time period in which the controlled substances prescription monitoring program's central database tracking system is suspended or is not operational or available in a timely manner. If the program's central database tracking system is not accessible, the medical practitioner or the medical practitioner's delegate shall document the date and time the practitioner or delegate attempted to use the central database tracking system pursuant to a process established by board rule.

N. The board shall conduct an annual voluntary survey of program users to assess user satisfaction with the program's central database tracking system. The survey may be conducted electronically. On or before December 1 of each year, the board shall provide a report of the survey results to the president of the senate, the speaker of the house of representatives and the governor and shall provide a copy of this report to the secretary of state.

O. This section does not prohibit a medical practitioner regulatory board from obtaining and using information from the program's central database tracking system.

P. For the purposes of this section, "emergency department" means the unit within a hospital that is designed for the provision of emergency services.
ARKANSAS

§ 20-7-615
ADC 007.07.4-VII
ADC 060.00.1-2
ADC 060.00.1-19
ADC 067.00.4-VIII
ADC 067.00.4-XII
ADC 069.00.1-V-IX1

Arkansas Code Annotated (2016)
Title 20. Public Health and Welfare
Subtitle 2. Health and Safety
Chapter 7. State Board of Health--Department of Health
Subchapter 6. Prescription Drug Monitoring Program Act

§ 20-7-615. Prescriber with a prescription drug violation

(a) A prescriber who has been found by his or her licensing board to be in violation of a rule or law involving prescription drugs shall be required by the appropriate licensing board to register with the Prescription Drug Monitoring Program and access patient information before writing a prescription for an opioid.

(b) The licensing board, in its discretion, may remove this requirement after a period of time if the board deems removal of the requirement appropriate.

Arkansas Administrative Code (2016)
Title 007. Department of Health
Division 07. Pharmacy Services
Rule 4. Regulations Pertaining to Prescription Drug Monitoring Program

007.07.4-VII. Providing Prescription Monitoring Information

(3)(A) A prescriber who has been found by his or her licensing board to be in violation of a rule or law involving prescription drugs shall be required by the appropriate licensing board to register with the Prescription Drug Monitoring Program and access patient information before writing a prescription for an opioid.

(B) The licensing board, in its discretion, may remove this requirement after a period of time if the board deems removal of the requirement appropriate.
Rule 1. Arkansas Medical Practices Regulations

060.00.1-2.

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c. Prescriber requirements:

i. For a patient with chronic nonmalignant pain, a prescriber, at a minimum and in addition to any additional requirements of the Arkansas State Medical Board, shall:

1. Check the prescriptive history of the patient on the Prescription Drug Monitoring Program at least every six (6) months;

2. Have a signed pain contract with the patient that states, at a minimum, the expectations of the prescriber for the behavior of the patient which may include:

   a. A requirement for random urine drug screenings to help ensure that the patient is abiding by the requirements of the contract; and

   b. A requirement for random pill counts to ensure compliance with the prescription.

ii. The requirements of this section shall not apply to a patient:

1. Whose pain medications are being prescribed for a malignant condition:

2. With a terminal condition;

3. Who is a resident of a licensed healthcare facility;

4. Who is enrolled in a hospice program; or

5. Who is in an inpatient or outpatient palliative care program.

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C. A prescriber who has been found by the Arkansas State Medical Board to be in violation of a rule or law involving prescription drugs shall be required by the appropriate licensing board to register with the Prescription Drug Monitoring Program and access patient information before writing a prescription for an opioid. The board, in its discretion, may remove this requirement after a period of time if the board deems removal of the requirement appropriate.
060.00.1-19. Pain Management Programs

a. Prescriber requirements:

i. For a patient with chronic nonmalignant pain, a prescriber, at a minimum and in addition to any additional requirements of the Arkansas State Medical Board, shall:

1. Check the prescriptive history of the patient on the Prescription Drug Monitoring Program at least every six (6) months;

2. Have a signed pain contract with the patient that states, at a minimum, the expectations of the prescriber for the behavior of the patient which may include:

   a. A requirement for random urine drug screenings to help ensure that the patient is abiding by the requirements of the contract; and

   b. A requirement for random pill counts to ensure compliance with the prescription.

ii. The requirements of this section shall not apply to a patient:

1. Whose pain medications are being prescribed for a malignant condition:

2. With a terminal condition;

3. Who is a resident of a licensed healthcare facility;

4. Who is enrolled in a hospice program; or

5. Who is in an inpatient or outpatient palliative care program.

A prescriber who has been found by his or her licensing board to be in violation of a rule or law involving prescription drugs shall be required by the Arkansas State Medical Board to register with the Prescription Drug Monitoring Program and access patient information before writing a prescription for an opioid. The licensing board, in its discretion, may remove this requirement after a period of time if the board deems removal of the requirement appropriate.

Arkansas Administrative Code (2016)
Title 067. Board of Nursing
Division 00.
Rule 4. Advanced Practice Registered Nurse

067.00.4-VIII. Prescriptive Authority

. . .
K. PRESCRIPTION DRUG MONITORING PROGRAM

1. APRNs may delegate access to the Prescription Drug Monitoring Program for running requested reports to no more than two licensed nurses under his or her supervision or employment at each practice location.

2. APRNs with prescriptive authority who have been found guilty, by the Board of Nursing, of violating a law or rule involving prescription drugs shall review a current report (run within the past 30 days) from the Prescription Drug Monitoring Program prior to prescribing an opioid. Review of this report shall be documented in the patient’s medical record.

Arkansas Administrative Code (2016)
Title 067. Board of Nursing
Division 00.
Rule 4. Advanced Practice Registered Nurse

067.00.4-XII. Prescribing for Chronic Nonmalignant Pain

A. Chronic nonmalignant pain is defined as pain requiring more than three consecutive months of prescriptions for:

1. An opioid that is written for more than the equivalent of ninety (90) tablets, each containing five (5) milligrams of hydrocodone; or

2. A morphine equivalent dose of more than fifteen mg (15 mg) per day; or

3. Tramadol - a prescription for one hundred twenty (120) or more, fifty (50) milligram tablets.

B. Patient Treatment and Evaluation

1. The patient shall be evaluated at least one (1) time every six (6) months by a physician who is licensed by the Arkansas State Medical Board.

2. A current Prescription Drug Monitoring Program report shall be reviewed at least every six (6) months. The review shall be documented in the patient’s medical record.

3. A current pain contract with the patient shall be maintained and include, at a minimum, requirements for:
   a. Random urine drug screens and
   b. Random pill counts

C. The requirements of this section shall not apply to a patient:
1. Whose pain medications are being prescribed for a malignant condition:

2. With a terminal condition;

3. Who is a resident of a licensed healthcare facility;

4. Who is enrolled in a hospice program; or

5. Who is in an inpatient or outpatient palliative care program.

West’s Arkansas Administrative Code (2016)
Title 069. Board of Optometry
Division 00.
Rule 1. Rules and Regulations of Arkansas State Board of Optometry
Chapter V. Rules, Regulations and Educational Qualifications Governing Optometrists Certified as Optometric Physicians Pursuant to Acts 176/186 of 1997
Article IX. Prescribing Controlled Substances.

069.00.1-V-IX1. Arkansas optometrist licensed as optometric physician who applies for and possess a DEA number shall:

. . .

E. A prescriber who has been found by the Arkansas State Board of Optometry to be in violation of a rule or law involving prescription drugs shall be required by the board to register with the Prescription Drug Monitoring Program and access patient information before writing a prescription for an opioid. The board, in its discretion, may remove this requirement after a period of time if the board deems removal of the requirement appropriate.

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CALIFORNIA

§ 11165.4 Health & Safety Code
S.B. 482 2016

<Section not operational until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, user support, and education.>

... 

11165.4. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient’s controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.
(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient’s controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, “first time” means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.
(2) A health care practitioner shall obtain a patient’s controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:
(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:
(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.
(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.
(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.
(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient’s treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:
   (A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.
   (B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.
   (C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.
   (D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.
   (E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:
   (i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.
   (ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.
   (iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.
   (B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient’s medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

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(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient’s inability to obtain a prescription in a timely manner and thereby adversely impact the patient’s medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

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COLORADO

2 CCR 502-1:21.320.3
7 CCR 1101-3:18

Colorado Administrative Code (2016)
Title 500. Department of Human Services
502. Behavioral Health
2 CCR 502-1. Care and Treatment of the Mentally Ill
502-1:21.300. Licensing of Addiction Programs Using Controlled Substances
502-1:21.320. Opioid Medication Assisted Treatment (Omat)

502-1:21.320.3. ADMINISTRATIVE AND MEDICAL RESPONSIBILITY

21.320.31 OMAT Program Sponsors

OMAT program sponsors are responsible for the following:

A. Overall operation of the program including, but not limited to:

1. Compliance with all applicable state and federal laws, rules, and regulations;

2. Medical and counseling personnel are qualified to provide opioid replacement treatment;

3. Individuals are enrolled on their own volition;

4. Full disclosure is made to individuals about opioids and their use in treatment.

5. Written, informed consents for opioid replacement treatment are signed by individuals eighteen (18) years of age and older;

6. Written, informed consents for all aspects of opioid replacement treatment are signed by parents, legal guardians or other responsible adults designated by appropriate state authorities for individuals under age eighteen (18) years old;

7. Individual/counselor ratios do not exceed fifty to one (50:1) for full-time counseling staff, forty (40) hours per week, and twenty five to one (25:1) for half-time counseling staff, twenty (20) hours per week;

8. Written (OMAT) policies and procedures are developed, implemented and maintained that are based on and in compliance with Department rules;

9. All reasonable and clinically indicated efforts are made to coordinate treatment with other healthcare and behavioral health providers. Documentation includes obtaining individuals' consent to release information to communicate with those practitioners.
10. Methadone and other controlled substances are disposed of in accordance with the federal regulations.

11. Printed acknowledgements are signed by patients and kept in patient records stating that they have been informed of the United States Department of Transportation regulation against the use of OTP prescribed methadone by commercial drivers and the possible loss of commercial driver's license if taking methadone for addiction is discovered.

B. Training

1. Training for new (OMAT) staff is documented in personnel records including, but not limited to provisions of Section 21.160.1, A, 3, and:

   a. Federal Opioid Medication Assisted Treatment regulations;

   b. OMAT treatment rules;

   c. OMAT policies and procedures;

   d. Clinical practices including, but not limited to:

      1) Protocols around special exception requests, phase level requests, and any take-home protocol such as holiday dosing, weekend dosing, hold doses, hospitalization of individuals, incarceration, nursing home stays, and courtesy dosing; and,

      2) All other items agreed upon in the State Memorandum of Understanding.

   e. Pharmacology of methadone including, but not limited to, loss of tolerance to opioids, dangerous drug or alcohol interactions, signs and symptoms of overdose, purpose of its use.

2. Annual training for OMAT staff including, but not limited to:

   a. Most current pharmacology of medications used, and clinical practices applicable to OMAT, including problems with interactions of medications.

   b. Review of federal and state regulations and rules.

   c. Review of current OMAT policies and procedures.

   d. Infectious disease risks and screening.

21.320.32 OMAT Medical Directors

A. Agencies shall have designated medical directors who shall authorize and oversee other physicians, other appropriately licensed and/or certified medical personnel and all medical services provided.
B. Medical directors and other medical healthcare providers shall currently possess and maintain licenses to practice medicine/nursing in compliance with the credentialing requirements of their own profession in Colorado as provided by Article 36, Title 12, C.R.S. OMAT medical directors shall assure appropriate credentials and training for other OMAT physicians and other qualified health care providers to deliver ORT.

C. Medical directors shall ensure that the OMAT agency is in compliance with all state and federal rules and regulations regarding medical treatment for opioid addiction.

D. OMAT medical directors, other OMAT physicians and authorized OMAT medical personnel shall ensure the following:

1. Medical evaluations including evidence of current physiological dependence and/or history of addiction or exceptions to admission criteria that are documented prior to initial dosing;

2. These medical evaluations are done at admission prior to initial dose.

3. The physical examinations and all appropriate laboratory tests are performed and reviewed within fourteen (14) calendar days following treatment admission;

4. All medical professionals shall educate individuals regarding risks and benefits of OMAT and document that individuals are entering voluntarily.

5. All medical orders are properly signed or countersigned including initial orders for approved controlled substances and other medications, subsequent dose increases or decreases, changes in take-home dose privileges, emergency situations and other special circumstances by the medical director.

E. Medical directors or other physicians shall review, countersign and date intake evaluations written by authorized medical personnel before initial doses may be administered to individuals. When medical directors and other physicians are not available on-site to review, countersign and date evaluations for admission written by medical personnel, required physician reviews may be conducted by telephone and initial doses may be administered to individuals on physicians’ verbal or standing orders. In such cases, medical personnel shall document in individual records that no physicians were available on site and that physician reviews were conducted by telephone. Medical directors or other physicians shall review and countersign authorizations.

F. Medical directors and other qualified health care professionals shall utilize the information obtained from the Colorado State Board of Pharmacy's electronic Prescription Drug Monitoring Program (PDMP) as clinically appropriate upon intake.

West's Colorado Administrative Code (2016)
Title 1100. Department of Labor and Employment
1101. Division of Workers' Compensation
7 CCR 1101-3. Workers’ Compensation Rules of Procedure

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(5) Chronic Opioid Management Report

(a) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and also review the Colorado State Board of Medical Examiners' Policy # 10-14, “Guidelines for the Use of Controlled Substances for the Treatment of Pain.” Urine drug tests for chronic opioid management shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for chronic opioid compliance monitoring.

(1) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.

(2) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).

(3) While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:

(i) Concern regarding the functional status of the patient

(ii) Abnormal results on previous testing

(iii) Change in management of dosage or pain

(iv) Chronic daily opioid dosage above 150 mg of morphine or equivalent

(4) The opioids prescribed for long-term treatment shall be provided through a pharmacy.

(5) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies.

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§ 21a-254
H.B. 5053 2016

Connecticut General Statutes Annotated (2016)
Title 21a. Consumer Protection
Chapter 420B. Dependency-Producing Drugs
Part I. General Provisions

§ 21a-254. Designation of restricted drugs or substances by regulations. Records required by chapter. Electronic prescription drug monitoring program

(j) (1) The commissioner shall, within available appropriations, establish an electronic prescription drug monitoring program to collect, by electronic means, prescription information for schedules II, III, IV and V controlled substances that are dispensed by pharmacies, nonresident pharmacies, as defined in section 20-627, outpatient pharmacies in hospitals or institutions or by any other dispenser. The program shall be designed to provide information regarding the prescription of controlled substances in order to prevent the improper or illegal use of the controlled substances and shall not infringe on the legitimate prescribing of a controlled substance by a prescribing practitioner acting in good faith and in the course of professional practice.

(9) Prior to prescribing greater than a seventy-two-hour supply of any controlled substance to any patient, the prescribing practitioner or such practitioner’s authorized agent shall review the patient’s records in the electronic prescription drug monitoring program established pursuant to this subsection. Whenever a prescribing practitioner prescribes a controlled substance, other than a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescriber, or such prescriber’s authorized agent, shall review, not less than once every ninety days, the patient’s records in such prescription drug monitoring program. Whenever a prescribing practitioner prescribes a schedule V nonnarcotic controlled substance, for the continuous or prolonged treatment of any patient, such prescribing practitioner, or such prescribing practitioner’s authorized agent, shall review, not less than annually, the patient’s records in such prescription drug monitoring program. If such electronic prescription drug monitoring program is not operational, such prescribing practitioner may prescribe greater than a seventy-two-hour supply of a controlled substance to a patient during the time of such program’s inoperability, provided such prescribing practitioner or such authorized agent reviews the records of such patient in such program not more than twenty-four hours after regaining access to such program.

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DELAWARE

16 § 4798

Delaware Code Annotated (2016)
Title 16. Health and Safety
Part IV. Food and Drugs
Chapter 47. Uniform Controlled Substances Act
Subchapter VII. Miscellaneous

§ 4798. The Delaware Prescription Monitoring Program

<Text of section effective upon the availability of appropriations, or of other adequate funding to implement and maintain the Prescription Monitoring Program and upon 3-1-2014.>

. . .

(e) When a dispenser has a reasonable belief that a patient may be seeking a controlled substance listed in Schedule II, III, IV or V for any reason other than the treatment of an existing medical condition, the dispenser shall obtain a patient utilization report regarding the patient for the preceding 12 months from the Prescription Monitoring Program before dispensing the prescription.

(f) A prescriber, or other person authorized by the prescriber, shall obtain, before writing a prescription for a controlled substance listed in Schedule II, III, IV or V for a patient, a patient utilization report regarding the patient for the preceding 12 months from the computerized program established by the Office of Controlled Substances when the prescriber has a reasonable belief that the patient may be seeking the controlled substance, in whole or in part, for any reason other than the treatment of an existing medical condition. The prescriber shall review the patient utilization report to assess whether the prescription for the controlled substance is necessary.

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GEORGIA

ADC 360-8-.02

West's Georgia Administrative Code (2016)
Title 360. Georgia Composite Medical Board
Chapter 360-8. Pain Management Clinics

360-8-.02. Standards of Operation

(1) Each location of a clinic where a physician practices pain management must be licensed.

(2) A new pain management clinic license must be obtained if there is a change in ownership or a change in location.

(3) No pain management clinic shall provide medical treatment or services unless a physician, a physician assistant authorized to prescribe controlled substances under an approved job description, or an advanced practice registered nurse authorized to prescribe controlled substances pursuant to a physician protocol is on-site at the pain management clinic. Nothing in this rule shall be construed to restrict the practice of a Georgia licensed Certified Registered Nurse Anesthetist administering anesthesia as provided in O.C.G.A. 43-34-11.1.

(4) No licensed physician can own a pain management clinic if the physician, during the course of his or her practice, has been denied the privilege of prescribing, dispensing, administering, supplying or selling any controlled substance, or has had board action against his or her medical license as a result of dependency on alcohol or drugs.

(5) No person can own a pain management clinic if he or she has been convicted of a felony. For purposes of this rule, the term “convicted of a felony” shall include a conviction of an offense which if committed in this state would be deemed a felony under either state or federal law, without regard to its designation elsewhere. As used in this paragraph, the term “conviction” shall include a finding or verdict of guilt, a plea of guilty resulting in first offender status, or a plea of nolo contendere in a criminal proceeding, regardless of whether the adjudication of guilt or sentence is withheld or not entered thereon.

(6) The owner of the clinic and the physicians practicing in the clinic shall be responsible for compliance with all the laws and rules and regulations regulating the practice of medicine and the laws and rules and regulations pertaining to the controlled substances.

(7) The license issued by the Board shall be displayed in a conspicuous place.

(8) All pain management clinics that dispense controlled substances or dangerous drugs shall be registered with the Georgia State Board of Pharmacy as required by Chapter 4 of Title 26.
(9) Each physician owning or practicing in a pain management clinic must register with the Georgia Prescription Monitoring Program (“PDMP”). See link www.gdna.ga.gov. **Each physician practicing at a pain clinic must regularly check the PDMP on all new and existing patients.**

(10) The Board shall have the power to reprimand, cancel, suspend, revoke, or otherwise restrict any license or permit issued by the Board.

(11) Any person who operates a pain management clinic in the State of Georgia without a license shall be guilty of a felony.

[Back to Top](#)
§ 35-48-7-12.1
§ 12-23-18-5.3
SEA 297 2016

West's Annotated Indiana Code (2016)
Title 35. Criminal Law and Procedure
Article 48. Controlled Substances
Chapter 7. Central Repository for Controlled Substances Data

§ 35-48-7-12.1 Adoption of rules to implement chapter; powers of board

Sec. 12.1. (a) The board shall adopt rules under IC 4-22-2 to implement this chapter, including the following:

(1) Information collection and retrieval procedures for the INSPECT program, including the controlled substances to be included in the program required under section 8.1 of this chapter.

(2) Design for the creation of the data base required under section 10.1 of this chapter.

(3) Requirements for the development and installation of online electronic access by the board to information collected by the INSPECT program.

(4) Identification of emergency situations or other circumstances in which a practitioner may prescribe, dispense, and administer a prescription drug specified in section 8.1 of this chapter without a written prescription or on a form other than a form specified in section 8.1(a)(4) of this chapter.

(5) Requirements for a practitioner providing treatment for a patient at an opioid treatment program operating under IC 12-23-18 to check the INSPECT program:

(A) before initially prescribing ephedrine, pseudoephedrine, or a controlled substance to a patient; and

(B) periodically during the course of treatment that uses ephedrine, pseudoephedrine, or a controlled substance.

(b) The board may:

(1) set standards for education courses for individuals authorized to use the INSPECT program;

(2) identify treatment programs for individuals addicted to controlled substances monitored by the INSPECT program; and

(3) work with impaired practitioner associations to provide intervention and treatment.
(c) The executive director of the Indiana professional licensing agency may hire a person to serve as the director of the INSPECT program, with the approval of the chairperson of the board.

West’s Annotated Indiana Code (2016)
Title 12. Human Services
Article 23. Addiction Services
Chapter 18. Methadone Diversion Control and Oversight Program

§ 12-23-18-5.3

Sec. 5.3. Subject to federal law and consistent with standard medical practices in opioid treatment for substance abuse, the division shall adopt rules under IC 4-22-2 concerning opioid treatment by an opioid treatment provider, including the following:

(1) A requirement that the opioid treatment provider periodically review with the patient the patient’s treatment plan. In the review, the opioid treatment provider shall consider changes to the plan with the goal of requiring the minimal clinically necessary medication dose, including, when appropriate, the goal of opioid abstinence.

(2) Treatment protocols containing best practice guidelines for the treatment of opiate dependent patients, including the following:

(A) Appropriate clinical use of all drugs approved by the federal Food and Drug Administration for the treatment of opioid addiction, including the following when available:

(i) Opioid maintenance.
(ii) Detoxification.
(iii) Overdose reversal.
(iv) Relapse prevention.
(v) Long acting, nonaddictive medication assisted treatment medications.

(B) Requirement of initial and periodic behavioral health assessments for each patient.

(C) Appropriate use of providing overdose reversal, relapse prevention, counseling, and ancillary services.

(D) Transitioning off agonist and partial agonist therapies with the goal, when appropriate, of opioid abstinence.

(E) Training and experience requirements for providers who treat and manage opiate dependent patients.

(F) Requirement that a provider who prescribes opioid medication for a patient periodically review INSPECT (as defined in IC 35-48-7-5.2) concerning controlled substance information for the patient.
KENTUCKY

§ 218A.172
201 KAR 8:540
201 KAR 9:016
201 KAR 9:260
201 KAR 20:057
201 KAR 25:090
902 KAR 20:430

Baldwin's Kentucky Revised Statutes Annotated (2016)
Title XVIII. Public Health
Chapter 218A. Controlled Substances

§ 218A.172 Administrative regulations on prescribing or dispensing of Schedule II controlled substance or Schedule III controlled substance containing hydrocodone; continuing course of treatment; recordkeeping; exemptions

(1) Administrative regulations promulgated under KRS 218A.205(3) shall require that, prior to the initial prescribing or dispensing of any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, a practitioner shall:

(a) Obtain a medical history and conduct a physical or mental health examination of the patient, as appropriate to the patient's medical complaint, and document the information in the patient's medical record;

(b) Query the electronic monitoring system established in KRS 218A.202 for all available data on the patient for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient;

(c) Make a written plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(e) Obtain written consent for the treatment.

(2) (a) Administrative regulations promulgated under KRS 218A.205(3) shall require that a practitioner prescribing or dispensing additional amounts of Schedule II controlled substances or Schedule III controlled substances containing hydrocodone for the same medical complaint and related symptoms shall:
1. Review, at reasonable intervals based on the patient's individual circumstances and course of treatment, the plan of care;

2. Provide to the patient any new information about the treatment; and

3. Modify or terminate the treatment as appropriate.

(b) If the course of treatment extends beyond three (3) months, the administrative regulations shall also require that the practitioner:

1. Query the electronic monitoring system established in KRS 218A.202 no less than once every three (3) months for all available data on the patient for the twelve (12) month period immediately preceding the query; and

2. Review that data before issuing any new prescription or refills for the patient for any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

Kentucky Administrative Regulations (2016)
Title 201. General Government Cabinet
Chapter 8. Board of Dentistry

201 KAR 8:540. Dental practices and prescription writing

Section 4. Prescribing of Controlled Substances by Dentist. (1) Prior to the initial prescribing of any controlled substance, each dentist shall:

(a) Except as provided in subsection (2) of this section, and review a KASPER report for all available data on the patient;

(b) Document relevant information in the patient's record;

(c) Consider the available information to determine if it is medically appropriate and safe to prescribe a controlled substance;

(d) Obtain a complete medical history and conduct a physical examination of the oral or maxillofacial area of the patient and document the information in the patient's medical record;

(e) Make a written treatment plan stating the objectives of the treatment and further diagnostic examinations required;

(f) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and
(g) Obtain written consent for the treatment.

(2) A dentist shall not be required to obtain and review a KASPER report if:

(a) 1. The dentist prescribes a Schedule III controlled substance or one (1) of the Schedule IV controlled substances listed in subsection (3) of this section after the performance of oral surgery; and

2. No more than a seventy-two (72) hour supply of the controlled substance is prescribed;

(b) The dentist prescribes or dispenses a Schedule IV or V controlled substance not listed in subsection (3) of this section; or

(c) 1. The dentist prescribes pre-appointment medication for the treatment of procedure anxiety; and

2. The prescription is limited to a two (2) day supply and has no refills.

(3) A dentist shall obtain and review a KASPER report before initially prescribing any of the following Schedule IV controlled substances:

(a) Ambien;

(b) Anorexics;

(c) Ativan;

(d) Klonopin;

(e) Librium;

(f) Nubain;

(g) Oxazepam;

(h) Phentermine;

(i) Soma;

(j) Stadol;

(k) Stadol NS;

(l) Tramadol;

(m) Versed; and
(n) Xanax.

(4) A dentist may provide one (1) refill within thirty (30) days of the initial prescription for the same controlled substance for the same amount or less or prescribe a lower schedule drug for the same amount without a clinical reevaluation of the patient by the dentist.

(5) A patient who requires additional prescriptions for a controlled substance shall be clinically reevaluated by the dentist and the provisions of this section, shall be followed.

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Kentucky Administrative Regulations (2016)
Title 201. General Government Cabinet
Chapter 9. Board of Medical Licensure

201 KAR 9:016. Restrictions on use of amphetamine and amphetamine-like anorectic controlled substances

. . .

Section 4. Treatment of Obesity with a Schedule III or IV Amphetamine-like Controlled Substance. (1) Prior to prescribing, administering, dispensing, ordering, selling, supplying, or giving a Schedule III or IV amphetamine-like controlled substance to treat obesity in a patient sixteen (16) years of age or older, the physician shall:

. . .

(2) During treatment for obesity, a physician shall:

(a) Maintain a physician/patient relationship throughout the treatment process;

(b) Maintain an adequate patient record in accordance with subsection (4) of this section; and

(c) Justify in the patient record the use of any Schedule III or IV amphetamine-like controlled substance beyond three (3) months. Before the physician continues the use of a substance beyond three (3) months, the physician shall obtain and review a current KASPER report.

. . .

Kentucky Administrative Regulations (2016)
Title 201. General Government Cabinet
Chapter 9. Board of Medical Licensure

201 KAR 9:260. Professional standards for prescribing and dispensing controlled substances

Section 1. Applicability. (1) A physician who is authorized to prescribe or dispense a controlled substance shall comply with the standards of acceptable and prevailing medical practice for prescribing and dispensing a controlled substance established in this administrative regulation.
(2) The professional standards established in this administrative regulation shall not apply to a physician prescribing or dispensing a controlled substance:

(a) To a patient as part of the patient's hospice or end-of-life treatment;

(b) To a patient admitted to a licensed hospital as an inpatient, outpatient, or observation patient, during and as part of a normal and expected part of the patient's course of care at that hospital;

(c) To a patient for the treatment of pain associated with cancer or with the treatment of cancer;

(d) To a patient who is a registered resident of a long-term-care facility as defined in KRS 216.510;

(e) During the effective period of any period of disaster or mass casualties which has a direct impact upon the physician's practice;

(f) In a single dose prescribed or dispensed to relieve the anxiety, pain, or discomfort experienced by that patient submitting to a diagnostic test or procedure; or

(g) That has been classified as a Schedule V controlled substance.

Section 3. Professional Standards for the Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a Primary Medical Complaint. Prior to the initial prescribing or dispensing of any controlled substance for pain or other symptoms associated with the same primary medical complaint, the first physician prescribing or dispensing a controlled substance shall:

(1) Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and:

(a) If the complaint does not relate to a psychiatric condition, conduct a physical examination of the patient relevant to the medical complaint and related symptoms and document the information in the patient's medical record; or

(b) If the complaint relates to a psychiatric condition, perform, or have performed by a psychiatrist or other designated mental health provider, an evaluation appropriate to the presenting complaint and document the relevant findings;

(2) Obtain and review a KASPER report for that patient for the twelve (12) month period immediately preceding the patient encounter, and appropriately utilize that information in the evaluation and treatment of the patient;

(3) After examining the benefits and risks of prescribing or dispensing a controlled substance to the patient, including nontreatment or other treatment, make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substance in the amount specified;
(4) Not prescribe or dispense a long-acting or controlled-release opioid (e.g. OxyContin, fentanyl patches, or methadone) for acute pain that is not directly related to and close in time to a specific surgical procedure;

(5) Explain to the patient that a controlled substance used to treat an acute medical complaint is for time-limited use, and that the patient should discontinue the use of the controlled substance when the condition requiring the controlled substance use has resolved; and

(6) Explain to the patient how to safely use and properly dispose of any unused controlled substance.

Section 5. Professional Standards for Continuing Long Term Prescribing or Dispensing of Controlled Substances for the Treatment of Pain and Related Symptoms Associated with a Primary Medical Complaint. (1) If a physician continues to prescribe or dispense a controlled substance beyond three (3) months to a patient sixteen (16) years or older for pain and related symptoms associated with the primary medical complaint, the physician shall comply with the professional standards established in subsection (2) of this section. These standards may be accomplished by different licensed practitioners in a single group practice at the direction of or on behalf of the prescribing physician as established in Section 4(1) of this administrative regulation.

(i)1. At least once every three (3) months, the physician shall obtain and review a current KASPER report, for the twelve (12) month period immediately preceding the request, and appropriately use that information in the evaluation and treatment of the patient.

2. If the physician obtains or receives specific information that the patient is not taking the controlled substance as directed, is diverting a controlled substance, or is engaged in any improper or illegal use of a controlled substance, the physician shall immediately obtain and review a KASPER report and appropriately use the information in the evaluation and treatment of the patient.

3. If a KASPER report discloses that the patient is obtaining a controlled substance from another practitioner without the physician's knowledge and approval, in a manner that raises suspicion of illegal diversion, the physician shall promptly notify the other practitioner of the relevant information from the KASPER review.

Section 7. Professional Standards for the Prescribing and Dispensing of Controlled Substances for the Treatment of Other Conditions. (1) Before initially prescribing or dispensing a controlled substance to a patient for a condition other than pain, the physician shall:
(a) Obtain an appropriate medical history relevant to the medical complaint, including a history of present illness, and:

1. If the complaint does not relate to a psychiatric condition, conduct a physical examination of the patient relevant to the medical complaint and related symptoms and document the information in the patient's medical record; or

2. If the complaint relates to a psychiatric condition, perform, or have performed by a psychiatrist or other designated mental health provider, an evaluation appropriate to the presenting complaint and document the relevant findings;

(b) Obtain and review a KASPER report for that patient, for the twelve (12) month period immediately preceding the patient encounter, and appropriately utilize that information in the evaluation and treatment of the patient;

3. If a physician receives a request from an established patient to prescribe or dispense a limited amount of a controlled substance to assist the patient in responding to the anxiety or depression resulting from a nonrecurring single episode or event, the physician shall:

(a) Obtain and review a KASPER report for that patient for the twelve (12) month period immediately preceding the patient request and appropriately utilize the information obtained in the evaluation and treatment of the patient;

(b) Make a deliberate decision that it is medically appropriate to prescribe or dispense the controlled substance in the amount specified, with or without requiring a personal encounter with the patient to obtain a more detailed history or to conduct a physical examination; and

(c) If the decision is made that it is medically appropriate to prescribe or dispense the controlled substance, prescribe or dispense the minimum amount of the controlled substance to appropriately treat the situational anxiety or depression.

Section 9. Additional Standards for Prescribing or Dispensing Schedule II Controlled Substances or Schedule III Controlled Substances Containing Hydrocodone. (1) In addition to the other standards established in this administrative regulation, prior to the initial prescribing or dispensing of a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, a physician shall:

(a) Obtain a medical history and conduct a physical or mental health examination of the patient, as appropriate to the patient's medical complaint, and document the information in the patient's medical record;

(b) Query KASPER for all available data on the patient for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient;
(c) Make a written plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(e) Obtain written consent for the treatment.

(2)(a) In addition to the other standards established in this administrative regulation, a physician prescribing or dispensing additional amounts of a Schedule II controlled substance or aSchedule III controlled substance containing hydrocodone for the same medical complaint and related symptoms shall:

1. Review, at reasonable intervals based on the patient's individual circumstances and course of treatment, the plan of care;

2. Provide to the patient any new information about the treatment; and

3. Modify or terminate the treatment as appropriate.

(b) If the course of treatment extends beyond three (3) months, the physician shall:

1. Query KASPER no less than once every three (3) months for all available data on the patient for the twelve (12) month period immediately preceding the query; and

2. Review that data before issuing any new prescription or refills for the patient for any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

. . .

(4) The additional standards for prescribing or dispensing a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone established in this section shall not apply to:

(a) A physician prescribing or administering that controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or delivery and the medication usage does not extend beyond the fourteen (14) days; or

(b) A physician prescribing or dispensing that controlled substance:

1. For administration in a hospital or long-term-care facility if the hospital or long-term-care facility with an institutional account, or a physician in those hospitals or facilities if no
institutional account exists, queries KASPER for all available data on the patient or resident for the twelve (12) month period immediately preceding the query, within twelve (12) hours of the patient's or resident's admission, and places a copy of the query in the patient's or resident's medical records for use during the duration of the patient's stay at the facility;

2. As part of the patient's hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing:
   a. Is done as a substitute for the initial prescribing or dispensing;
   b. Cancels any refills for the initial prescription; and
   c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing is done by another physician in the same practice or in an existing coverage arrangement, if done for the same patient for the same medical condition; or

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federal wide assurance number from the United States Department for Health and Human Services, Office for Human Research Protections if the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health.

Section 10. Violations. (1) Any violation of the professional standards established in this administrative regulation shall constitute a violation of KRS 311.595(12) and (9), which may result in the imposition of disciplinary sanctions by the board, pursuant to KRS 311.595.

(2) Each violation of the professional standards established in this administrative regulation shall be established by expert testimony by one (1) or more physicians retained by the board, following a review of the licensee's patient records and other available information including KASPER reports.

Kentucky Administrative Regulations (2016)
Title 201. General Government Cabinet
Chapter 20. Board of Nursing
201 KAR 20:057. Scope and standards of practice of advanced practice registered nurses

Section 9. Prescribing Standards for Controlled Substances. (1)(a) This section shall apply to an APRN with a CAPA-CS if prescribing a controlled substance other than a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(b) The APRN shall practice according to the applicable scope and standards of practice for the APRN’s role and population focus.

(2) This section shall not apply to:

(a) An APRN prescribing or administering a controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or the delivery and the medication usage does not extend beyond the fourteen (14) days;

(b) An APRN prescribing or administering a controlled substance necessary to treat a patient in an emergency situation; or

(c) An APRN prescribing a controlled substance:

1. For administration in a hospital or long-term-care facility with an institutional account, or an APRN in a hospital or facility without an institutional account, if the hospital, long-term-care facility, or licensee queries KASPER for all available data on the patient or resident for the twelve (12) month period immediately preceding the query within twelve (12) hours of the patient’s or resident’s admission and places a copy of the query in the patient’s or resident’s medical records during the duration of the patient’s stay at the facility;

2. As part of the patient’s hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing pursuant to subsection (1) of this section if the prescribing:

   a. Is done as a substitute for the initial prescribing;

   b. Cancels any refills for the initial prescription; and

   c. Requires the patient to dispose of any remaining unconsumed medication;
(3) The APRN shall, prior to initially prescribing a controlled substance for a medical complaint for a patient:

(a) Obtain the patient’s medical history and conduct an examination of the patient and document the information in the patient’s medical record. An APRN certified in psychiatric/mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient’s medical record;

(b) Query KASPER for all available data on the patient;

(c) Make a written treatment plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss with the patient, the patient’s parent if the patient is an unemancipated minor child, or the patient’s legal guardian or health care surrogate:

1. The risks and benefits of the use of controlled substances, including the risk of tolerance and drug dependence;

2. That the controlled substance shall be discontinued when the condition requiring its use has resolved; and

3. Document that the discussion occurred and that the patient consented to the treatment.

(6) During the course of treatment, the APRN shall query KASPER no less than once every three (3) months for all available data on the patient before issuing a new prescription or a refill for a controlled substance.

(7) These requirements may be satisfied by other licensed practitioners in a single group practice if:

(a) Each licensed practitioner involved has lawful access to the patient’s medical record;

(b) Each licensed practitioner performing an action to meet these requirements is acting within the scope of practice of his or her profession; and

(c) There is adequate documentation in the patient’s medical record reflecting the actions of each practitioner.

(10) If prescribing a controlled substance for a patient younger than sixteen (16) years of age, the APRN shall obtain and review an initial KASPER report. If prescribing a controlled substance for an individual sixteen (16) years of age or older, the requirements of this section shall apply.
(11) Prior to prescribing a controlled substance for a patient in the emergency department of a hospital that is not an emergency situation as specified in subsection (2) of this section, the APRN shall:

(a) Obtain the patient’s medical history, conduct an examination of the patient and document the information in the patient’s medical record. An APRN certified in psychiatric/mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient’s medical record;

(b) Query KASPER for all available data on the patient;

(c) Make a written treatment plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient’s parent if the patient is an unemancipated minor child, or the patient’s legal guardian or health care surrogate, including the risk of tolerance and drug dependence, and document that the discussion occurred and that the patient consented to the treatment.

Section 10. Prescribing Standards for Controlled Substances from Schedule II and Schedule III Containing Hydrocodone. (1)(a) This section shall apply to an APRN with a CAPA-CS if prescribing a controlled substance from Schedule II or Schedule III controlled substance containing hydrocodone.

(b) The APRN shall practice according to the applicable scope and standards of practice for the APRN’s role and population focus.

(2) This section shall not apply to:

(a) An APRN prescribing or administering a controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or the delivery and the medication usage does not extend beyond the fourteen (14) days;

(b) An APRN prescribing or administering a controlled substance necessary to treat a patient in an emergency situation; or

(c) An APRN prescribing a controlled substance:

1. For administration in a hospital or long-term-care facility with an institutional account, or an APRN in a hospital or facility without an institutional account, if the hospital, long-term-care facility, or licensee queries KASPER for all available data on the patient or resident for the twelve (12) month period immediately preceding the query within twelve (12) hours of the patient’s or resident’s admission and places a copy of the query in the
patient’s or resident’s medical records during the duration of the patient’s or resident’s stay at the facility;

2. As part of the patient’s hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing pursuant to subsection (1) of this section if the prescribing or dispensing:
   a. Is done as a substitute for the initial prescribing;
   b. Cancels any refills for the initial prescription; and
   c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescribing pursuant to subsection (1) of this section if the prescribing is done by another licensee in the same practice or in an existing coverage arrangement, if done for the same patient for the same medical condition; or

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federal-wide assurance number from the United States Department of Health and Human Services, Office for Human Research Protections if the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health.

(3) Prior to the initial prescribing of a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, an APRN shall:

(a) Obtain a medical history and conduct a physical or mental health examination of the patient, as appropriate to the patient’s medical complaint, and document the information in the patient’s medical record;

(b) Query the electronic monitoring system established in KRS 218A.202 for all available data on the patient for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient;

(c) Make a written plan stating the objectives of the treatment and further diagnostic examinations required;
(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient’s parent if the patient is an unemancipated minor child, or the patient’s legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(e) Obtain written consent for the treatment.

(4)(a) An APRN prescribing an additional amount of a Schedule II controlled substance or Schedule III controlled substance containing hydrocodone for the same medical complaint and related symptoms shall:

1. Review the plan of care at reasonable intervals based on the patient’s individual circumstances and course of treatment;

2. Provide to the patient any new information about the treatment; and

3. Modify or terminate the treatment as appropriate.

(b) If the course of treatment extends beyond three (3) months, the licensee shall:

1. Query KASPER no less than once every three (3) months for all available data on the patient for the twelve (12) month period immediately preceding the query; and

2. Review that data before issuing any new prescription or refills for the patient for any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

Kentucky Administrative Regulations (2016)
Title 201. General Government Cabinet
Chapter 25. Board of Podiatry

201 KAR 25:090. Prescribing and dispensing controlled substances

Section 1. Prescribing or dispensing a controlled substance. (1) This administrative regulation governs the prescribing and dispensing of controlled substances listed in Schedule II through V as classified in KRS 218A.060, 218A.070, 218A.080, 218A.090, 218A.100, 218A.110, 218A.120, and 218A.130.

(2) If initially prescribing or dispensing a controlled substance, a licensee shall:

(a) Obtain a complete medical history and conduct a physical examination of the patient;

(b) Complete a written treatment plan which states the objectives of the treatment underlying the prescription of the controlled substance and which includes an outline of any further diagnostic examinations that may be required;
(c) Discuss the risks and benefits of the use of controlled substances with the patient or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence;

(d) Verify that the patient is the person that he or she has identified himself or herself as being by requiring the person to produce proper government issued identification;

(e) Query the Kentucky All-Schedule Prescription Electronic Reporting System (KASPER) for all information available on the patient if prescribing controlled substances that are included in:

1. Schedule II;

2. Schedule III; and

3. The following from Schedule IV:

a. Ambien;

b. Anorexics;

c. Ativan;

d. Klonopin;

e. Librium;

f. Nubain;

g. Oxazepam;

h. Phentermine;

i. Soma;

j. Stadol;

k. Stadol NS;

l. Tramadol;

m. Valium;

n. Versed; and

o. Xanax;
(f) Obtain consent for the treatment from the patient in writing; and

(g) Document the patient's file as required by Section 2 of this administrative regulation.

(3) If it is necessary to continue the prescription or dispensation of a controlled substance after the initial supply is completed, a licensee shall:

(a) Conduct, at reasonable intervals under the circumstances presented, all clinically indicated steps;

(b) Review the course of treatment that he initially prepared to determine if any changes are required;

(c) Provide any new information about the course of treatment or any changes made to the patient;

(d) Query KASPER for all information available on the patient no less than once every three months for all available data on the patient to review that data before issuing any new prescription or refill for the patient for controlled substance specified in subsection (2)(e) of this section; and

(e) Document the patient's file as required by Section 2 of this administrative regulation.

Section 2. Podiatric medical records for patients being prescribed controlled substance shall include at a minimum:

(1) The patient's name;

(2) The patient's date of birth;

(3) The information concerning the patient's medical history and physical examination required by Section 1 of this administrative regulation;

(4) The podiatrist's diagnosis of the patient's condition;

(5) The procedures and treatments to be undertaken and their objectives;

(6) The date of the procedures or treatments;

(7) Whether local or general anesthetics were used, including the type and the amount administered;

(8) Diagnostic, therapeutic, and laboratory results;

(9) The findings and recommendations of any other evaluations or consultations;
(10) All medications administered or prescribed by the podiatrist, including the date, type, dosage, and quantity administered or prescribed;

(11) Any post-treatment instructions from the podiatrist; and

(12) Documentation that the KASPER query required by Section 3 of this administrative regulation was completed.

Section 3. If a prescription for a controlled substance is written, a podiatrist shall:

(1) Obtain and document in the patient's podiatric medical record the information concerning the patient's medical history and physical examination required by Section 1 of this administrative regulation;

(2) Query the Kentucky All-Scheduled Prescription Electronic Reporting System (KASPER) for all available data on the patient if the controlled substance is one specified in Section 1(2)(e) of this administrative regulation and record the results of the query in the patient's record;

(3) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(4) Obtain consent for the treatment from the patient in writing.

Section 4. Dispensing Schedule II or Schedule III controlled substances containing hydrocodone.

(1) A licensee shall not dispense more than a forty-eight (48) hour supply of Schedule II or Schedule III controlled substances containing hydrocodone.

(2) If a patient continues to present with pain after the initial supply has been completed and the podiatrist believes that an additional prescription for a controlled substance is medically appropriate, the podiatrist shall at a minimum:

(a) Follow the requirements of Section 1 of this administrative regulation; and

(b) Prescribe only that amount of the controlled substance that is appropriate under accepted and prevailing practice standards.

Section 5. Authority to prescribe controlled substances. (1) A podiatrist licensed by the board may prescribe any medicine necessary for the treatment of a patient that comes within the practice of podiatry as defined by KRS 311.380(2), including Schedule II and Schedule III controlled substances containing hydrocodone, if the licensee:

(a) Has obtained a license number from the Drug Enforcement Administration;
(b) Registers with and utilizes the Kentucky All-Schedule Prescription Electronic Reporting System (KASPER) as required by KRS 218A.202;

(c) Follows the requirements of this administrative regulation; and

(d) Meets all the requirements for utilizing KASPER promulgated by the Cabinet as well as the requirements set forth in KRS 218A.202.

(2) A licensed podiatrist shall not prescribe or dispense:

(a) With the intent or knowledge that a medication will be used or is likely to be used for any purpose other than one that is necessary for medical treatment or therapeutic use;

(b) With the intent to evade any law governing the sale, use, or disposition of the medication;

(c) When the licensee knows or has reason to know that the abuse of the controlled substance is occurring or may result therefrom; and

(d) In amounts that the licensee knows or has reason to know, under the circumstance, that the amount prescribed is excessive under accepted and prevailing practice standards.

(3) After a hearing conducted under KRS Chapter 13B and 201 KAR 25:051, the board shall fine a licensee who otherwise has the authority to prescribe controlled substances, but who has failed to register for an account with KASPER, an amount not less than $250 per prescription for each prescription that individual has written while not properly registered.

Kentucky Administrative Regulations (2016)
Title 902. Cabinet for Health and Family Services - Department for Public Health
Chapter 20. Health Services and Facilities

902 KAR 20:430. Facilities specifications, operation and services; behavioral health services organizations

(3) Excluding methadone-based treatment which is restricted to regulation under 908 KAR 1:340, a behavioral health services organization may employ or have an affiliation with a physician or physicians who prescribe FDA-approved drugs for the treatment of opioid addiction in adult patients. The behavioral health services organization shall comply with the following requirements:

(a) Ensure that the physician documents in the patient’s record whether the patient is compliant with prescribed dosing as evidenced by the results of:

1. A KASPER report released to the physician pursuant to KRS 218A.202(6)(e); and

2. Drug testing;
(b) Offer individual and group outpatient therapy as a service and document monitoring of compliance with recommended non-medication therapies even if the therapies are provided in another behavioral health setting; and

(c) Ensure that the physician complies with the prescribing and dispensing standards in 201 KAR 9:270 for FDA-approved drugs used for the treatment of opioid addiction.
LOUISIANA

§ 40:978
§ 40:1046
ADC Title 48, Part I, § 7831
ADC Title 46, Part XLV, § 7717

West's Louisiana Statutes Annotated (2016)
Louisiana Revised Statutes
Title 40. Public Health and Safety
Chapter 4. Food and Drugs
Part X. Uniform Controlled Dangerous Substances Law

§ 978. Prescriptions

F. A prescriber shall access the Prescription Monitoring Program prior to initially prescribing any Schedule II controlled dangerous substance to a patient for the treatment of non-cancer-related chronic or intractable pain.

West’s Louisiana Statutes Annotated (2016)
Louisiana Revised Statutes
Title 40. Public Health and Safety
Chapter 4. Food and Drugs
Part X-E. Therapeutic Use of Marijuana

§ 1046. Recommendation of marijuana for therapeutic use; rules and regulations; Louisiana Board of Pharmacy and the adoption of rules and regulations relating to the dispensing of recommended marijuana for therapeutic use; the Department of Agriculture and Forestry and the licensure of a production facility

F. A person who recommends and a person who dispenses marijuana, tetrahydrocannabinols, or a chemical derivative of tetrahydrocannabinols pursuant to this Section shall review the patient’s information in the Prescription Monitoring Program database prior to the recommending and dispensing thereof.

Louisiana Administrative Code (2016)
Title 48. Public Health—General
Part I. General Administration Subpart 1. General
Subpart 3. Licensing and Certification
Chapter 78. Pain Management Clinics
Subchapter C. Clinic Administration

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§ 7831. Medical Director

6. The medical director is responsible for applying to access and query the Louisiana Prescription Monitoring Program (PMP).

   a. The PMP is to be utilized by the medical director and the pain specialist as part of the clinic’s quality assurance program to ensure adherence to the treatment agreement signed by the patient.

      i. The treatment agreement states that the patient has been informed that he shall only obtain and receive narcotic prescriptions from the clinic where he is being treated for chronic pain.

         (a). The patient shall be subject to periodic unannounced drug screens and shall not participate in diversion of any controlled dangerous substance.

   b. Compliance to this agreement is to be determined, evaluated, and documented at each subsequent visit to a clinic when the patient receives a prescription for a controlled dangerous substance.

Louisiana Administrative Code (2016)
Title 46. Professional and Occupational Standards
Part XLV. Medical Professions
Subpart 3. Practice
Chapter 77. Marijuana for Therapeutic Use by Patients Suffering from a Qualifying Medical Condition
Subchapter D. Marijuana for Therapeutic Purposes, Limitations, Access to Records

§ 7717. Use of Marijuana for Therapeutic Purposes, Limitations

2. Prescription Monitoring Program. The physician shall review the patient’s information in the Prescription Monitoring Program database prior to issuing any written request or recommendation for marijuana.

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MAINE

22 § 7253
L.D. 1646 2016
02-373 CMR Ch. 2, § 5

Maine Revised Statutes Annotated (2016)
Title 22. Health and Welfare
Subtitle 4. Human Services
Part 3. Drug Abuse
Chapter 1603. Controlled Substances Prescription Monitoring

§ 7253. Prescribers and dispensers required to check prescription monitoring information.

1. Prescribers. On or after January 1, 2017, upon initial prescription of a benzodiazepine or an opioid medication to a person and every 90 days for as long as that prescription is renewed, a prescriber shall check prescription monitoring information for records related to that person.

2. Dispensers. On or after January 1, 2017, a dispenser shall check prescription monitoring information prior to dispensing a benzodiazepine or an opioid medication to a person under any of the following circumstances:

A. The person is not a resident of this State;
B. The prescription is from a prescriber with an address outside of this State;
C. The person is paying cash when the person has prescription insurance on file; or
D. According to the pharmacy prescription record, the person has not had a prescription for a benzodiazepine or an opioid medication in the previous 12-month period.

A dispenser shall notify the program and withhold a prescription until the dispenser is able to contact the prescriber of that prescription if the dispenser has reason to believe that the prescription is fraudulent or duplicative.

3. Exception; hospital setting and facilities. When a licensed or certified health care professional directly orders or administers a benzodiazepine or opioid medication to a person in an emergency room setting, an inpatient hospital setting, a long-term care facility or a residential care facility, the requirements to check prescription monitoring information established in this section do not apply.

4. Violation. A person who violates this section commits a civil violation for which a fine of $250 per incident, not to exceed $5,000 per calendar year, may be adjudged.

5. Rulemaking. Notwithstanding section 7252, the department may adopt routine technical rules as defined in Title 5, chapter 375, subchapter 2-A to implement this section.
Sec. 5. UNIFORM ELEMENTS OF WRITTEN PLANS OF SUPERVISION

1. All written plans of supervision shall include at a minimum:

A. The physician assistant's scope of practice and practice setting, including the types of patients and patient encounters common to the practice, a general overview of the role of the physician assistant in the practice, and the tasks that the physician assistant may delegate to medical assistants.

B. A description of the type and level of supervision, including:

(6) A description of the mechanism and process for evaluating the physician assistant's performance. Such a process must include:

(a) Primary Supervising Physician. At least two documented meetings each licensure year between each primary supervising physician and the physician assistant during the physician assistant's two-year licensing cycle to evaluate the physician assistant's performance (semi-annual evaluations). All four semiannual evaluations shall be documented on a form attached to the most current plan of supervision. If the primary supervising physician supervises the physician assistant for less than six months of a licensure year, only one evaluation need be completed for that licensure year. Semi-annual evaluations must be signed by the primary supervising physician and the physician assistant and the information must be kept by the physician assistant. Each semi-annual meeting evaluation shall address the following areas:

(i) clinical and procedural care delivery, including physician assistant supervision of medical assistants;

(ii) patient relations and professionalism;

(iii) documentation review. It is recommended that a representative sample of patient charts be reviewed on a routine basis; and

(iv) prescriptive practices. Special attention shall be devoted to the prescribing of controlled substances, if such prescribing is authorized. If controlled substances are prescribed a review of Prescription Monitoring Program reports shall be conducted.

(b) Secondary Supervising Physician. If the physician assistant is routinely working under the supervision of a secondary supervising physician who is a medical specialist (i.e. cardiologist, neurologist, etc.) outside of the primary supervising physician's field of practice, then the secondary supervising physician shall also perform semi-annual evaluations that shall address the following areas:

(a) clinical and procedural care delivery, including physician assistant supervision of medical assistants;

(b) patient relations and professionalism;
(c) documentation review. It is recommended that a representative sample of patient charts be reviewed on a routine basis; and

(d) prescriptive practices. Special attention shall be devoted to the prescribing of controlled substances, if such prescribing is authorized. If controlled substances are prescribed a review of Prescription Monitoring Program reports shall be conducted.

…
MARYLAND

Health-General § 21-2A-04.2
H.B. 437 2016

Annotated Code of Maryland (2016)
Health--General
Title 21. Food, Drugs, and Cosmetics
Subtitle 2a. Prescription Drug Monitoring Program

§ 21-2A-04.2

(a)(1) Beginning July 1, 2018, a prescriber:

(i) Shall request at least the prior 4 months of prescription monitoring data for a patient before initiating a course of treatment for the patient that includes prescribing or dispensing an opioid or a benzodiazepine;

(ii) Shall, if a patient’s course of treatment continues to include prescribing or dispensing an opioid or a benzodiazepine for more than 90 days after the initial request for prescription monitoring data, request prescription monitoring data for the patient at least every 90 days until the course of treatment has ended; and

(iii) Shall assess the prescription monitoring data requested from the Program before deciding whether to prescribe or dispense or continue prescribing or dispensing an opioid or a benzodiazepine.

(2) If a prescriber decides to prescribe or continue to prescribe an opioid or a benzodiazepine after requesting prescription monitoring data from the Program and assessing the prescription monitoring data, the prescriber shall document in the patient’s medical record that the prescription monitoring data was requested and assessed.

(b) A prescriber is not required to request prescription monitoring data from the Program if the opioid or benzodiazepine is prescribed or dispensed to an individual:

(1) In an amount indicated for a period not to exceed 3 days;

(2) For the treatment of cancer or cancer-related pain;

(3) Who is:

(i) A patient receiving treatment in an inpatient unit of a hospital;

(ii) 1. A patient in a general hospice care program as defined in § 19-901 of this article; or

2. Any other patient diagnosed with a terminal illness;

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(iii) A patient who resides in:

1. An assisted living facility;
2. A long-term care facility;
3. A comprehensive care facility;
4. A developmental disabilities facility; or

(4) To treat or prevent acute pain for a period of not more than 14 days following:

(i) A surgical procedure in which general anesthesia was used;
(ii) A fracture;
(iii) Significant trauma; or
(iv) Childbirth.

(c) A prescriber may not be required to comply with the provisions of this section when:

(1) Prescribing or dispensing an opioid or a benzodiazepine drug that has been listed by the Secretary under § 21-2A-03(b)(3) of this subtitle as having a low potential for abuse;

(2) Accessing prescription monitoring data would result in a delay in the treatment of a patient that would negatively impact the medical condition of the patient;

(3) Electronic access to prescription monitoring data is not operational as determined by the Department; or

(4) Prescription monitoring data cannot be accessed by the prescriber due to a temporary technological or electrical failure.

(d) If a prescriber does not access prescription monitoring data for any of the reasons provided under subsection (c)(2), (3), or (4) of this section:

(1) The prescriber shall use reasonable medical judgment in determining whether to prescribe or dispense an opioid or a benzodiazepine; and

(2) The prescriber shall enter an appropriate record in the patient’s medical chart, including the reason why prescription monitoring data was not accessed.
(e) If a pharmacist or pharmacist delegate has a reasonable belief that a patient may be seeking a monitored prescription drug for any purpose other than the treatment of an existing medical condition:

(1) Before dispensing a monitored prescription drug to the patient, the pharmacist or pharmacist delegate shall request prescription monitoring data to determine if the patient has received other prescriptions that indicate misuse, abuse, or diversion of a monitored prescription drug; and

(2) The pharmacist shall have the responsibility described in 21 C.F.R. § 1306.04.

(f) The Secretary may adopt regulations to provide additional clinical, technical, or administrative exemptions based on new standards of practice.
MASSACHUSETTS

94C § 24A (eff. Oct. 15, 2016)
H.B. 4056
105 CMR 700.012
105 CMR 725.010
234 CMR 5.06
243 CMR 2.07
244 CMR 4.07
247 CMR 9.04
249 CMR 4.02
263 CMR 5.07

Massachusetts General Laws Annotated (2016)
Part I. Administration of the Government
Title XV. Regulation of Trade
Chapter 94C. Controlled Substances Act

§ 24A. Electronic monitoring of the prescribing and dispensing of controlled substances and certain additional drugs

...<Text of Section (c) Effective October 15, 2016>

(c) For the purposes of monitoring the prescribing and dispensing of all schedule II to V, inclusive, controlled substances and additional drugs, as authorized in subsection (a), the department shall promulgate regulations including, but not limited to, (1) a requirement that each pharmacy that delivers a schedule II to V, inclusive, controlled substance or a substance classified as an additional drug by the department to the ultimate user shall submit to the department, by electronic means, information regarding each prescription dispensed for a drug included under subsection (a); and (2) a requirement that each pharmacy collects and reports, for each prescription dispensed for a drug under subsection (a), a customer identification number and other information associated with the customer identification number, as specified by the department. Each pharmacy shall submit the information in accordance with transmission methods and frequency requirements promulgated by the department; provided, however, that the information shall be submitted at least once every 24 hours. The department may issue a waiver to a pharmacy that is unable to submit prescription information by electronic means. The waiver shall permit the pharmacy to submit prescription information by other means promulgated by the department; provided, however, that all information required in this section is submitted in this alternative format.

The department shall promulgate rules and regulations relative to the use of the prescription monitoring program by registered participants, which shall include the requirement that prior to issuance, participants shall utilize the prescription monitoring program each time a prescription for a narcotic drug that is contained in Schedule II or III...
is issued. The department may require participants to utilize the prescription monitoring program prior to the issuance, to a patient for the first time, of benzodiazepines or any other schedule IV or V prescription drug, which is commonly abused and may lead to physical or psychological dependence or which causes patients with a history of substance dependence to experience significant addictive symptoms. The regulations shall specify the circumstances under which such narcotics may be prescribed without first utilizing the prescription monitoring program. The regulations may also specify the circumstances under which support staff may use the prescription monitoring program on behalf of a registered participant. When promulgating the rules and regulations, the department shall also require that pharmacists be trained in the use of the prescription monitoring program as part of the continuing education requirements mandated for licensure by the board of registration in pharmacy, under section 24A of chapter 112. The department shall also study the feasibility and value of expanding the prescription monitoring program to include schedule VI prescription drugs.

Code of Massachusetts Regulations (2016)
Title 105: Department of Public Health
Chapter 700.000: Implementation of M.G.L. C. 94c

700.012: Prescription Monitoring Program

(H) Requirement to Utilize the Prescription Monitoring Program.

(1) A registered individual practitioner must utilize the prescription monitoring program prior to prescribing, to a patient for the first time:

(a) a narcotic drug in Schedule II or III; or

(b) a benzodiazepine; or

(c) a Schedule IV or V controlled substance, as designated in guidance to be issued by the Department.

(2) A registered individual practitioner must utilize the prescription monitoring program each time the prescriber issues a prescription to a patient for any drug in Schedule II or III which has been determined by the Department to be commonly misused or abused and which has been designated as a drug that needs additional safeguards in guidance to be issued by the Department.

(a) The Department shall convene an advisory group to develop this guidance.

(b) The advisory group shall consist of nine members, chaired by the Commissioner or the Commissioner’s designee, and must include experts in the fields of medicine, nursing, pharmacy, pain management treatment, addiction treatment, academia, and law enforcement.
(c) The advisory group will hold a public hearing before each revision to the guidance and shall invite comment prior to adding any drug to the guidance.

(d) The advisory group shall meet no less than one time a year and as many times as needed. Each member shall serve a three year term.

(3) 105 CMR 700.012(H)(1) and (2) shall not apply to:

(a) A registered individual practitioner authorized to prescribe, administer, possess, order, or dispense samples of controlled substances only in Schedule VI;

(b) A registered individual practitioner providing medical, dental, podiatric, pharmaceutical, or nursing care to hospice patients;

(c) A registered individual practitioner treating a patient in an Emergency Department who does not anticipate writing a prescription for a controlled substance in Schedules II-V during that encounter with the patient or does not prescribe more than a five-day supply of a controlled substance in Schedules II-V;

(d) An instance in which emergency care is required and in the professional opinion of the prescriber utilization of the prescription monitoring program is likely to result in patient harm;

(e) A registered individual practitioner providing medical, dental, podiatric, pharmaceutical or nursing care to hospital inpatients;

(f) A registered individual practitioner providing medications for immediate treatment in accordance with M.G.L. c. 94C, § 9(b);

(g) An instance in which it is not reasonably possible to utilize the prescription monitoring program, including when the system is not operational due to temporary technological or electrical failure;

(h) A registered individual practitioner examining or treating a patient under 96 months of age;

(i) A registered individual practitioner granted a waiver pursuant to 105 CMR 700.012(1); and

(j) Other exceptions as defined in guidance issued by the Department

(I) Waiver of Requirement to Utilize the Prescription Monitoring Program.

(1) The Department may waive the requirements established in 105 CMR 700.012(H)(1) and (2) for a participant who submits a request, in a manner and form determined by the Department, if the Department determines that a waiver is appropriate based on the criteria listed in 105 CMR 700.012(I)(2).
(2) A request for a waiver of the requirements in 105 CMR 700.012(H)(1) and (2) shall include a
description of the following:

(a) The participant’s history of compliance with laws and regulations related to controlled
substances;

(b) A substantial hardship created by a natural disaster or other emergency beyond the control of
the participant;

(c) Technological limitations not reasonably within control of the participant; or

(d) Temporary technological limitations within the control of the participant that will be rectified
within six months.

Code of Massachusetts Regulations (2016)
Title 105: Department of Public Health
Chapter 725.000: Implementation of an Act for the Humanitarian Medical Use of Marijuana

725.010: Certifying Physician's Written Certification of a Debilitating Medical Condition for a
Qualifying Patient

(A) A certifying physician issuing a written certification on or after July 1, 2014, must have
completed a minimum of 2.0 Category 1 continuing professional development credits as defined
in 243 CMR 2.06(6)(a)1. Such program must explain the proper use of marijuana, including side
effects, dosage, and contraindications, including with psychotropic drugs, as well as on substance
abuse recognition, diagnosis, and treatment related to marijuana.

(B) A certifying physician issuing a written certification shall comply with generally accepted
standards of medical practice, including regulations of the Board of Registration in Medicine at
243 CMR 1.00 through 3.00.

(C) A certifying physician may not delegate to any other health care professional or any other
person, authority to diagnose a patient as having a debilitating medical condition.

(D) A certifying physician may issue a written certification only for a qualifying patient with
whom the physician has a bona fide physician-patient relationship.

(E) Before issuing a written certification, a certifying physician must utilize the
Massachusetts Prescription Monitoring Program, unless otherwise specified by the
Department, to review the qualifying patient's prescription history.

Code of Massachusetts Regulations (2016)
Title 234: Board of Registration in Dentistry
Chapter 5.00: Requirements for the Practice of Dentistry and Dental Hygiene
5.06: Controlled Substances

(1) Dentists registered to dispense, administer and prescribe any controlled substances shall do so in accordance with M.G.L. c. 94C and 105 CMR 700.00 and all applicable state and federal statutes and regulations pertaining to controlled substances.

(2) Dentists are limited to writing prescriptions for controlled substances for legitimate dental purposes in the usual course of practice and are prohibited from prescribing controlled substances in Schedules II-IV for personal use.

(3) Except in an emergency, a dentist is prohibited from prescribing Schedule II controlled substances to a member of his/her immediate family including a spouse (or equivalent), parent, child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-child, step-sibling, or other relative permanently residing in the same residence as the licensee.

(4) Prior to prescribing hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient’s risk factors, substance abuse history, presenting condition(s), current medication(s) and a check of the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient’s diagnoses, treatment plan, and risk assessment;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy that includes the patient’s diagnoses and treatment plan, verifies that other pain management treatments have failed, indicates that a risk assessment was performed and that the licensee and the patient have entered into a Pain Management Treatment Agreement; and

(e) Document 234 CMR 5.06(4)(a) through (d) in the patient’s medical record.

Code of Massachusetts Regulations (2016)
Title 243: Board of Registration in Medicine
Chapter 2.00: The Practice of Medicine

2.07: General Provisions Governing the Practice of Medicine

243 CMR 2.07 addresses some issues relating to the practice of medicine by licensees. The Practice of Medicine is defined in 243 CMR 2.01(4). . .
(25) Prescribing Hydrocodone-only Extended-release Medication. Prior to prescribing hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient’s risk factors, substance abuse history, presenting condition(s), current medication(s) and a check of the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient’s diagnoses, treatment plan, and risk assessment;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy that includes the patient’s diagnoses and treatment plan, verifies that other pain management treatments have failed, indicates that a risk assessment was performed and that the licensee and the patient have entered into a Pain Management Treatment Agreement; and

(e) Document 243 CMR 2.07(25)(a) through (d) in the patient’s medical record.

The purpose of 243 CMR 2.07(25) is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 243 CMR 2.07(25) shall alter the standard of care a licensee must use when prescribing any Schedule II, III or IV controlled substance.

Code of Massachusetts Regulations (2016)
Title 244: Board of Registration in Nursing
Chapter 4.00: Advanced Practice Registered Nursing

4.07: APRN Eligible to Engage in Prescriptive Practice

. . .

(3) Prescribing Hydrocodone-only Extended Release Medication.

Prior to prescribing a hydrocodone-only extended release medication that is not in an abuse deterrent form, an APRN engaged in prescriptive practice must:

(a) Thoroughly assess the patient, including an evaluation of the patient's risk factors, substance abuse history, presenting condition(s), current medication(s), a determination that other pain management treatments are inadequate, and a check of the patient's data through the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;
(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient's diagnoses, treatment plan, and risk assessment unless a Pain Management Treatment Agreement in not clinically indicated due to the severity of the patient's medical condition;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy pursuant to 247 CMR 9.04(8)(c); and

(e) Document 244 CMR 4.28(a) through (d) in the patient's medical record.

The purpose of 244 CMR 428 is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 244 CMR 4.28 shall alter the standard of care a licensee must use when prescribing any Schedule II, III or IV controlled substance.

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Code of Massachusetts Regulations (2016)
Title 247: Board of Registration in Pharmacy
Chapter 9.00: Code of Professional Conduct; Professional Standards for Registered Pharmacists, Pharmacies and Pharmacy Departments

9.04: Requirements for Dispensing and Refilling Prescriptions

(1) Whenever a prescription drug has been distributed solely under a generic name, the dispensing pharmacist shall record on the prescription the name of the manufacturer or, if the manufacturer's name is not available, the name of the distributor, packer, or repacker.

(2) The information on the label which the pharmacist, pharmacy intern, pharmacy technician or pharmacy technician trainee affixes to a prescription drug container shall be clearly printed or typed.

(3) Only a pharmacist, pharmacy intern, and certified pharmacy technician who has the approval of the pharmacist on duty may receive new prescriptions over the telephone from a prescriber or authorized agent.

(4) A pharmacist who refills a prescription for a controlled substance in Schedules III through VI shall record on the prescription:

(a) the date of dispensing;

(b) the amount of the drug dispensed; and

(c) his or her initials.
(5) A dispensing pharmacist who does not indicate the quantity of a drug dispensed on the back of a prescription which the pharmacist has refilled shall be deemed to have dispensed a refill for the full face amount of the prescription.

(6) Subject to the provisions of federal regulations at 21 CFR 1306, an automated data-processing system may be used as an alternative to the provisions of 247 CMR 9.04 (4) and (5). This data-processing system may be used for the storage and retrieval of information pertaining to the refilling of prescriptions for controlled substances in Schedules III through VI.

(7) A pharmacist or anyone acting on behalf of a pharmacy or pharmacy department shall not collect prescriptions at industrial plants, places of business, or other sites where specific groups of people are regularly employed or affiliated, unless the prescriptions meet the following requirements:

(a) the prescriptions are for persons regularly employed at, or affiliated with, such plant, place of business or other such site;

(b) the prescriptions are collected in person by a pharmacist, pharmacy employee, or authorized agent of the pharmacy;

(c) the prescriptions are distributed in person to the patients or an authorized agent of the patient by a pharmacist, pharmacy employee, or authorized agent of the pharmacy; and

(d) the pharmacist shall be responsible for the conduct of any pharmacy employee or authorized agent acting on the pharmacist's behalf, and for verifying the authority of any person purporting to act on a patient's behalf; nothing in 247 CMR 9.04(7) shall be deemed to permit conduct of a prescription business in violation of any other regulation of the Board.

(8) A pharmacist may not fill or dispense any prescription for a hydrocodone-only extended release medication that is not in an abuse deterrent form unless:

(a) the medication is stored in a securely locked and substantially constructed cabinet at all times while on pharmacy premises;

(b) the medication is dispensed in a container with a child proof safety cap or within a locked box;

(c) the prescriber has supplied a Letter of Medical Necessity for each prescription that is compliant with 243 CMR 2.07(25): Prescribing Hydrocodone-only Extended-release Medication and that includes the patient’s diagnoses and treatment plan, verifies other pain management treatments have failed, and indicates a risk assessment was performed and the prescriber and patient entered into a Pain Management Treatment Agreement and the pharmacist keeps the Letter of Medical Necessity in a readily retrievable manner;
(d) each prescription is accompanied by a written warning approved by the Board regarding the specific dangers of hydrocodone-only extended release medication that is not in abuse deterrent form;

(e) the pharmacist provides counseling that includes a review of the written warning supplied in accordance with 247 CMR 9.04(8)(c) and may include, but is not limited to:

1. the name and description of the medication;

2. the dosage form, dosage, route of administration and duration of drug therapy;

3. special instructions and precautions for preparation, administration and use by the patient;

4. common adverse or severe side effects or interactions and therapeutic contraindications;

5. techniques for self-monitoring drug therapy;

6. proper storage;

7. prescription refill information;

8. action to be taken in the event of a missed dose; and

(f) the pharmacist checks the patient’s history on the online Prescription Monitoring Program.

Code of Massachusetts Regulations (2016)
Title 249: Board of Registration in Podiatry
Chapter 4.00: Practice of Podiatric Medicine

4.02: Drug Dispensing and Prescribing

(1) In accordance with M.G.L. c. 94C, a podiatrist has the same rights in possessing, administering, dispensing and prescribing drugs as other practitioners and may prescribe, dispense and administer all reasonable substances which shall include but not be limited to all prescription drugs and controlled substances; or he or she may cause the same to be administered under his or her direction by a nurse.

(2) Prior to prescribing a hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient's risk factors, substance abuse history, presenting condition(s), current medication(s), a determination that other pain management treatments are inadequate, and a check of the patient's data through the online Prescription Monitoring Program;
(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient's diagnoses, treatment plan, and risk assessment unless a Pain Management Treatment Agreement is not clinically indicated due to the severity of the patient's medical condition;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy pursuant to 247 CMR 9.04(8)(c); and

(e) Document 249 CMR 4.02(2)(a) through (d) in the patient's medical record.

The purpose of 249 CMR 4.02(2) is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 249 CMR 4.02(2) shall alter the standard of care a licensee must use when prescribing any Schedule II, III or IV controlled substance.

Code of Massachusetts Regulations (2016)
Title 263: Board of Registration of Physician Assistants
Chapter 5.00: Scope of Practice and Employment of Physician Assistants

5.07: Prescription Practices of a Physician Assistant

. . .

(12) Prescribing Hydrocodone-only Extended-release Medication. Prior to prescribing a hydrocodone-only extended release medication that is not in an abuse deterrent form, a licensee must:

(a) Thoroughly assess the patient, including an evaluation of the patient's risk factors, substance abuse history, presenting condition(s), current medication(s), a determination that other pain management treatments are inadequate, and a check of the patient's data through the online Prescription Monitoring Program;

(b) Discuss the risks and benefits of the medication with the patient;

(c) Enter into a Pain Management Treatment Agreement with the patient that shall appropriately address drug screening, pill counts, safe storage and disposal and other requirements based on the patient's diagnoses, treatment plan, and risk assessment unless a Pain Management Treatment Agreement is not clinically indicated due to the severity of the patient's medical condition;

(d) Supply a Letter of Medical Necessity as required by the Board of Registration in Pharmacy pursuant to 247 CMR 9.04(8)(c); and

(e) Document 263 CMR 5.07(12)(a) through (d) in the patient's medical record.
The purpose of 263 CMR 5.07(12) is to enhance the public health and welfare by promoting optimum therapeutic outcomes, avoiding patient injury and eliminating medication errors. Nothing in 263 CMR 5.07(12) shall alter the standard of care a licensee must use when prescribing any Schedule II, III or IV controlled substance.
MINNESOTA

§ 245A.192
§ 256B.0638

Minnesota Statutes Annotated (2016)
Public Welfare and Related Activities
Chapter 245A. Human Services Licensing

§ 245A.192. Providers licensed to provide treatment of opioid addiction

Subd. 11. Prescription monitoring program. (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program for each client. The policy and procedure must include how the program will meet the requirements in paragraph (b).

(b) If a medication used for the treatment of opioid addiction is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, clients must be notified in writing that the commissioner of human services and the medical director will monitor the prescription monitoring program to review the prescribed controlled drugs the clients have received;

(2) the medical director or the medical director’s delegate must review the data from the Minnesota Board of Pharmacy prescription monitoring program (PMP) established under section 152.126 prior to the client being ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client file;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician’s review of the data and subsequent actions must be documented in the client’s individual file within 72 hours and must contain the medical director’s determination of whether or not the prescriptions place the client at risk of harm and the actions to be taken in response to the PMP findings. In addition, the provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client’s consent to discuss the client’s opioid treatment with other prescribers and must seek consent for the other prescriber to disclose to the opioid treatment program’s medical director the client’s condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director
must document whether or not changes to the client’s medication dose or number of take-home
doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and
implement an electronic system through which the commissioner shall routinely access the data
from the Minnesota Board of Pharmacy prescription monitoring program established under
section 152.126 for the purpose of determining whether any client enrolled in an opioid addiction
treatment program licensed according to this section has also been prescribed or dispensed a
controlled substance in addition to that administered or dispensed by the opioid addiction
treatment program. When the commissioner determines there have been multiple prescribers or
multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner
determined the existence of multiple prescribers or multiple prescriptions of controlled
substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review
the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any
applicable provision of Code of Federal Regulations, title 42, section 2.34(c), prior to
implementing this subdivision.

Minnesota Statutes Annotated (2016)
Public Welfare and Related Activities
Chapter 256B. Medical Assistance for Needy Persons

§ 256B.0638. Opioid prescribing improvement program

Subd. 5. Program implementation. (a) The commissioner shall implement the programs within
the Minnesota health care program to improve the health of and quality of care provided to
Minnesota health care program enrollees. The commissioner shall annually collect and report to
opioid prescribers data showing the sentinel measures of their opioid prescribing patterns
compared to their anonymized peers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the
opioid prescriber is employed or affiliated when the opioid prescriber’s prescribing pattern
exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any
provider group that receives a notice under this paragraph shall submit to the commissioner a
quality improvement plan for review and approval by the commissioner with the goal of bringing
the opioid prescriber’s prescribing practices into alignment with community standards. A quality
improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);
(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner’s notice under paragraph (b), the opioid prescriber’s prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber’s prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall terminate from Minnesota health care programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

...
MISSISSIPPI

ADC 24-2:59.2
ADC 30-17-2640:1.15

West's Mississippi Administrative Code (2016)
Title 24. Mental Health
Chapter 59. Opioid Treatment Services Utilizing Methadone

24-2:59.2. Admissions to Opioid Treatment Programs

E. Each individual must be reviewed prior to admission and annually thereafter from the date of admission on the Prescription Drug Monitoring Program (PDMH) in MS and nearby states for which access is available to assess for appropriateness of Opiate Treatment Services. No individual is eligible for admission or continued services/treatment whose review indicates the potential for diversion and/or abuse of Methadone.

West's Mississippi Administrative Code (2016)
Title 30. Professions and Occupations
Subtitle 17. Board of Medical Licensure
Part 2640. Prescribing, Administering and Dispensing
Chapter 1. Rules Pertaining to Prescribing, Administering and Dispensing of Medication


I. Physicians and physician assistants practicing in a registered pain practice must be registered with the Mississippi Prescription Monitoring Program (MPMP). A report shall be obtained on the initial visit and at intervals deemed appropriate for good patient care from the MPMP for every patient receiving controlled substances in a registered pain management practice.
NEVADA

§ 453.1545
§ 639.23507

Nevada Revised Statutes Annotated (2016)
Title 40. Public Health and Safety
Chapter 453. Controlled Substances
Uniform Controlled Substances Act
General Provisions

§ 453.1545. Development of computerized program to track prescriptions for controlled substances; course of training required for persons who access database; reporting of illegal activity; agreements with state agency of another state to receive or exchange information obtained by program; confidentiality of information obtained from program; immunity from liability for practitioner who transmits certain required information and reports; gifts, grants and donations

5. Each practitioner who is authorized to write prescriptions for controlled substances listed in schedule II, III or IV shall, to the extent the program allows, access the database of the program established pursuant to subsection 1 at least once each 6 months to:

(a) Review the information concerning the practitioner that is listed in the database and notify the Board if any such information is not correct; and

(b) Verify to the Board that he or she continues to have access to and has accessed the database as required by this subsection.

Nevada Revised Statutes Annotated (2016)
Title 54. Professions, Occupations and Businesses
Chapter 639. Pharmacists and Pharmacy
Prescriptions

§ 639.23507. Patient utilization report required before writing prescription for controlled substance

A practitioner shall, before initiating a prescription for a controlled substance listed in schedule II, III or IV, obtain a patient utilization report regarding the patient from the computerized program established by the Board and the Investigation Division of the Department of Public Safety pursuant to NRS 453.1545 if:

1. The patient is a new patient of the practitioner; or
2. The prescription is for more than 7 days and is part of a new course of treatment for the patient.

The practitioner shall review the patient utilization report to assess whether the prescription for the controlled substance is medically necessary.

3. If a practitioner who attempts to obtain a patient utilization report as required by subsection 1 fails to do so because the computerized program is unresponsive or otherwise unavailable, the practitioner:

(a) Shall be deemed to have complied with subsection 1 if the practitioner documents the attempt and failure in the medical record of the patient.

(b) Is not liable for the failure.

4. The Board shall adopt regulations to provide alternative methods of compliance with subsection 1 for a physician while he or she is providing service in a hospital emergency department. The regulations must include, without limitation, provisions that allow a hospital to designate members of hospital staff to act as delegates for the purposes of accessing the database of the computerized program and obtaining patient utilization reports from the computerized program on behalf of such a physician.

5. A practitioner who violates subsection 1:

(a) Is not guilty of a misdemeanor.

(b) May be subject to professional discipline if the appropriate professional licensing board determines that the practitioner’s violation was intentional.

6. As used in this section, “initiating a prescription” means originating a new prescription for a new patient of a practitioner or originating a new prescription to begin a new course of treatment for an existing patient of a practitioner. The term does not include any act concerning an ongoing prescription that is written to continue a course of treatment for an existing patient of a practitioner.
NEW HAMPSHIRE

§ 318-B:39
S.B. 576-FN-A 2016
Adc Part Med 502. Opioid Prescribing
Adc Part Nur 502. Opioid Prescribing
Adc Part Den 503. Opioid Prescribing

Revised Statutes Annotated of the State of New Hampshire (2016)
Title XXX. Occupations and Professions
Chapter 318-B. Controlled Drug Act
Controlled Drug Prescription Health and Safety Program

318-B:39 Prescribers Required to Query the Program Prior to Prescribing Controlled Substances.

Prescribers required to register with the program under this subdivision shall query the program for a patient’s initial prescription when prescribing schedule II, III, and IV opioids for the management or treatment of pain and then periodically and at least twice per year, except when:

I. Controlled medications are to be administered to patients in a health care setting.

II. Treating acute pain associated with serious traumatic injury, post-operatively, or with an acute medical condition, with clear objective findings by the practitioner, for no more than 30 days.

New Hampshire Adc Part Med 502. Opioid Prescribing,

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Med 502.05 Prescription Drug Monitoring Program. Prescribers required to register with the program under RSA 318-B:31-40, or their delegate, shall query the prescription drug monitoring program to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of this patient’s pain and then periodically and at least twice per year, except when:
(a) Controlled medications are to be administered to patients in a health care setting; or
(b) Treating acute pain associated with serious traumatic injury, post-operatively, or with an acute medical condition, with clear objective findings by the practitioner, for no more than 30 days.

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New Hampshire Adc Part Nur 502. Opioid Prescribing,

...
Nur 502.05 Prescription Drug Monitoring Program. Prescribers required to register with the program under RSA 318-B:31-40, or their delegate, shall query the Prescription Drug Monitoring Program to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of this patient’s pain and then periodically and at least twice per year, except when:
(a) Controlled medications are to be administered to patients in a health care setting; or
(b) Treating acute pain associated with serious traumatic injury, post-operatively, or with an acute medical condition, with clear objective findings by the practitioner, for no more than 30 days.


Den 503.06 Prescription Drug Monitoring Program. Prescribing licensees required to register with the program under RSA 318-B:31-40, or their delegate, shall query the prescription drug monitoring program to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of this patient’s pain and then periodically and at least twice per year, except when:
(a) Controlled medications are to be administered to patients in a health care setting; or
(b) Treating acute pain associated with serious traumatic injury, post-operatively, or with an acute medical condition, with clear objective findings by the practitioner, for no more than 30 days.

Back to Top
NEW JERSEY

§ 45:1-46.1

New Jersey Statutes Annotated (2016)
Title 45. Professions and Occupations
Subtitle 1. Professions and Occupations Regulated by State Boards of Registration and Examination
Chapter 1. General Provisions
[Article 3.3. Prescription Monitoring Program

§ 45:1-46.1. Practitioners authorized to access prescription monitoring information; Schedule II controlled dangerous substances

a. (1) Except as provided in subsection b. of this section, a practitioner or other person who is authorized by a practitioner to access prescription monitoring information pursuant to subsection h. of section 26 of P.L.2007, c. 244 (C.45:1-46) shall access prescription monitoring information the first time the practitioner or other person prescribes a Schedule II controlled dangerous substance to a new patient for acute or chronic pain. In addition, for any prescription of a Schedule II controlled dangerous substance for a new or current patient for acute or chronic pain which is written on or after the effective date of P.L.2015, c. 74 (C.45:1-46.1 et al.) a practitioner or other authorized person shall access prescription monitoring information on a quarterly basis during the period of time the patient continues to receive such prescriptions.

(2)(a) A pharmacist shall not dispense a Schedule II controlled dangerous substance to any person without first accessing the prescription monitoring information, as authorized pursuant to subsection h. of section 26 of P.L.2007, c. 244 (C.45:1-46), to determine if the person has received other prescriptions that indicate misuse, abuse, or diversion, if the pharmacist has a reasonable belief that the person may be seeking a controlled dangerous substance, in whole or in part, for any purpose other than the treatment of an existing medical condition, such as for purposes of misuse, abuse, or diversion.

(b) A pharmacist shall not dispense a prescription to a person other than the patient for whom the prescription is intended, unless the person picking up the prescription provides personal identification to the pharmacist, and the pharmacist, as required by subsection b. of section 25 of P.L.2007, c. 244 (C.45:1-45), inputs that identifying information into the Prescription Monitoring Program if the pharmacist has a reasonable belief that the person may be seeking a controlled dangerous substance, in whole or in part, for any reason other than delivering the substance to the patient for the treatment of an existing medical condition. The provisions of this subparagraph shall not take effect until the director determines that the Prescription Monitoring Program has the technical capacity to accept such information.

b. The provisions of subsection a. of this section shall not apply to:
(1) a veterinarian;
(2) a practitioner or the practitioner’s agent administering methadone, or another controlled dangerous substance designated by the director as appropriate for treatment of a patient with a substance abuse disorder, as interim treatment for a patient on a waiting list for admission to an authorized substance abuse treatment program;

(3) a practitioner administering a controlled dangerous substance directly to a patient;

(4) a practitioner prescribing a controlled dangerous substance to be dispensed by an institutional pharmacy, as defined in N.J.A.C.13:39-9.2;

(5) a practitioner prescribing a controlled dangerous substance in the emergency department of a general hospital, provided that the quantity prescribed does not exceed a five-day supply of the substance;

(6) a practitioner prescribing a controlled dangerous substance to a patient under the care of a hospice;

(7) a situation in which it is not reasonably possible for the practitioner or pharmacist to access the Prescription Monitoring Program in a timely manner, no other individual authorized to access the Prescription Monitoring Program is reasonably available, and the quantity of controlled dangerous substance prescribed or dispensed does not exceed a five-day supply of the substance;

(8) a practitioner or pharmacist acting in compliance with regulations promulgated by the director as to circumstances under which consultation of the Prescription Monitoring Program would result in a patient’s inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of the patient;

(9) a situation in which the Prescription Monitoring Program is not operational as determined by the division or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation;

(10) a practitioner or pharmacist who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner or pharmacist, or other exceptional circumstances demonstrated by the practitioner or pharmacist, pursuant to a process established in regulation, and in the discretion of the director; or

(11) a practitioner who is prescribing a controlled dangerous substance to a patient immediately after the patient has undergone an operation, procedure, or treatment for acute trauma, when less than a 30-day supply is prescribed.
NEW MEXICO

S.B. 263 2016
ADC 16.5.57
ADC 16.10.14
ADC 16.11.2
ADC 16.12.9
ADC 16.16.15
ADC 16.17.5
ADC 16.19.4
ADC 16.21.9

New Mexico Statutes Annotated (2016)
Chapter 26. Drugs and Cosmetics

New Section. Opioids – Requiring Practitioners to Obtain and Review Reports from the Prescription Monitoring Program.

<Text of Section Effective January 1, 2017>

A. For purposes of this section:

(1) “opioid” means the class of drugs that includes the natural derivatives of opium, which are morphine and codeine, and related synthetic and semi-synthetic compounds that act upon opioid receptors;

(2) “practitioner” does not include a pharmacist, veterinarian or euthanasia technician;

(3) “prescription monitoring program” means a program that includes a centralized system to collect, monitor and analyze electronically, for Schedule II through V controlled substances, prescribing and dispensing data submitted by dispensers; and

(4) “Schedule II through V controlled substance” means a substances listed in Schedule II, III, IV or V pursuant to the Controlled Substances Act or the federal controlled substances regulation, pursuant to 21 U.S.C. 812.

B. Before a practitioner prescribes or dispenses an opioid for the first time to a patient, the practitioner shall obtain and review a report from the state’s prescription monitoring program for such patient for the previous twelve calendar months. If the practitioner has access to a similar report from an adjacent state for the patient, the practitioner shall also obtain and review that report. The provisions of this subsection shall not apply to the prescription or dispensing of an opioid for a supply of four days or less.
C. A practitioner shall obtain and review a report from the state’s prescription monitoring program and similar reports from an adjacent state, if any, no less than once every three months for each established patient for whom the practitioner continuously prescribes or dispenses opioids.

D. A practitioner shall document the receipt and review of reports required by this section in the patient’s medical record.

E. Nothing in this section shall be construed to prevent a practitioner from obtaining and reviewing a report regarding a practitioner’s patient from the state’s prescription monitoring program or a similar report from another state with greater frequency than that required by this section, in accordance with the practitioner’s professional judgment.

F. Nothing in this section shall be construed to require a practitioner to obtain a prescription monitoring report when prescribing an opioid to a patient in a nursing facility or in hospice care.

G. The professional licensing board of each category of practitioner that is licensed or otherwise authorized to prescribe or dispense an opioid shall promulgate rules to implement the provisions of this section. Nothing in this section shall be construed to prevent a professional licensing board from requiring by rule that practitioners obtain prescription monitoring program reports with greater frequency than that required by this section.

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 5. Dentistry (Dentists, Dental Hygienists, etc.)
Part 57. Management of Pain with Controlled Substances

16.5.57. MANAGEMENT OF PAIN WITH CONTROLLED SUBSTANCES

16.5.57.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of requiring participation in the PMP is to assist dentists in balancing the safe use of controlled substances with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. A dentist who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A dentist shall before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when one of the following exists:

(1) the patient is a new patient of the dentist, in which situation a patient PMP report for the previous 12 months shall only be required when Schedules II, III and IV drugs are prescribed for a period greater than 10 days; and
(2) during the continuous use of controlled substances by established patients a PMP shall be requested a minimum of once every six months.

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 10. Medicine and Surgery Practitioners
Part 14. Management of Pain with Controlled Substances

16.10.14.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the New Mexico medical board in requiring participation in the PMP is to assist practitioners in balancing the safe use of controlled substances with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. A health care practitioner who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A health care practitioner shall, before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when one of the following situations exists:

(1) the patient is a new patient of the practitioner, in which situation a patient PMP report for the previous 12 months shall only be required when Schedules II, III, and IV drugs are prescribed for a period greater than 10 days; and

(2) during the continuous use of opioids by established patients a PMP shall be requested and reviewed a minimum of once every six months.

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 11. Midwives
Part 2. Certified Nurse Midwives

16.11.2. CERTIFIED NURSE MIDWIVES

C. Guidelines for management of chronic pain with controlled substances. The treatment of chronic pain with various modalities, including controlled substances such as opiates and opioids, is a legitimate practice when done in the usual course of CNM practice. The goal when treating chronic pain is to reduce or eliminate pain and also to avoid development of or contribution to addiction, drug abuse and overdosing. Effective dosages should be prescribed,
with both under- and over-prescribing to be avoided, using patient protection as a guiding principle. The CNM should provide control of the patient's pain for its duration, while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. A CNM may treat patients with addiction, physical dependence or tolerance who have legitimate pain, however such patients require very close monitoring and precise documentation.

(1) If, in a CNM's professional opinion, a patient is seeking pain medication for reasons that are not medically justified, the CNM is not required to prescribe controlled substances for the patient.

(2) When prescribing, dispensing or administering controlled substances for management of chronic pain, a CNM shall:

(a) obtain a PMP report for the patient covering the preceding 12 months from the New Mexico board of pharmacy, or another state's report where applicable and available;

(b) complete a history and physical examination and include an evaluation of the patient's psychological and pain status, any previous history of significant pain, past history of alternate treatments for pain, potential for substance abuse, coexisting disease or medical conditions, and the presence of medical indications or contra-indications related to controlled substances;

(c) be familiar with and employ screening tools, as well as the spectrum of available modalities for therapeutic purposes, in the evaluation and management of pain, and consider an integrative approach to pain management in collaboration with other care providers, including but not limited to acupuncturists, chiropractors, doctors of oriental medicine, exercise physiologists, massage therapists, pharmacists, physical therapists, psychiatrists or psychologists;

(d) develop a written individual treatment plan taking age, gender and culture into consideration, with stated objectives by which treatment can be evaluated, such as degree of pain relief, improved physical and psychological function, or other accepted measures, and including any need for further testing, consultation, referral or use of other treatment modalities as appropriate;

(e) discuss the risks and benefits of using controlled substances with the patient or legal guardian and document this discussion in the record;

(f) make a written agreement with the patient or legal guardian outlining patient responsibilities, including that the chronic pain patient will receive all chronic pain management prescriptions from one practitioner and one pharmacy whenever possible;

(g) maintain complete and accurate records of care provided and drugs prescribed, including the indications for use, the name of the drug, quantity, prescribed dosage and number of refills authorized;
(h) when indicated by the patient's condition, consult with health care professionals who are experienced in the area of the chronic pain, though not necessarily specialists in pain control, both early in the course of long-term treatment and at least every six months;

(i) when treating patients with drug addiction or physical dependence, use drug screening prior to and during the course of treatment to identify actual drugs being consumed and to compare with patients' self reports (this should be included in the written agreement, see Subparagraph (f) above);

(j) note the following possible indications of drug abuse by a patient and take appropriate steps to further investigate and to avoid contributing to drug abuse; such steps may include termination of treatment; some of this information may be available only though PMP reports;

(i) receiving controlled substances from multiple prescribers;

(ii) receiving controlled substances for more than 12 consecutive weeks;

(iii) receiving more than one controlled substance analgesic;

(iv) receiving a new prescription for any long-acting controlled substance analgesic formulation, including oral or transdermal dosage forms or methadone;

(v) overutilization, early refills;

(vi) appearing overly sedated or intoxicated upon presentation; or

(vii) an unfamiliar patient requesting a controlled substance by specific name, street name, color, or identifying marks.

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 12. Nursing and Health Care Related Providers
Part 9. Management of Chronic Pain with Controlled Substances

16.12.9. MANAGEMENT OF CHRONIC PAIN WITH CONTROLLED SUBSTANCES

16.12.9.9 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the NM board of nursing in requiring participation in the PMP is to assist practitioners in balancing the promotion of the safe use of controlled substances for the provision of nursing care and services with the need to impede illegal and harmful activities involving these pharmaceuticals.
A. A health care provider who holds a federal drug enforcement administration registration and licensure to prescribe opioids shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. Upon prescribing, ordering, administering or dispensing a controlled substance, the practitioner shall obtain and review a prescription monitoring report covering at least a one year time period or another state's report, where applicable and available. The practitioner shall be aware of a person currently:

(1) receiving opiates from multiple prescribers;

(2) receiving opiates for more than twelve consecutive weeks;

(3) receiving more than one controlled substance analgesic;

(4) receiving a new prescription for any long-acting controlled substance analgesic formulation, including oral dosage forms and transdermal (e.g. fentanyl) or methadone;

(5) exhibiting potential for abuse or misuse of opiates (i.e. over-utilization, early refills, appears overly sedated or intoxicated upon presentation, or an unfamiliar patient requesting an opiate by specific name, street name, color, or identifying marks, or paying cash when the patient has prescription insurance).

C. Upon recognizing any of the above, the practitioner, using professional judgment, shall take appropriate steps to avoid or resolve the potential problem. These steps may include requesting and reviewing additional controlled substance prescription monitoring reports or another state's report if applicable and available, or consulting with a pain management specialist or addiction treatment specialist or counseling the patient, which may include termination of treatment. The practitioner shall document steps taken to resolve the potential problem, which may include termination from treatment.

D. After obtaining an initial prescription monitoring report on a patient, the practitioner shall use professional judgment based on prevailing standards of practice in deciding the frequency of requesting and reviewing further prescription monitoring reports or other state's report on that patient. Prescription monitoring reports shall be requested and reviewed a minimum of once every six months during the continuous use of opioids for each established patient. The practitioner shall document the review of these reports.

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 16. Optometric Practitioner
Part 15. Management of Pain with Controlled Substances

16.16.15. MANAGEMENT OF PAIN WITH CONTROLLED SUBSTANCES

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16.16.15.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the optometry board requiring participation in the PMP is to assist optometrists in balancing the safe use of controlled substances with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. An optometrist who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. An optometrist shall, before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule III or IV, obtain a patient PMP report for the preceding 12 months when one of the following exists:

(1) for a new patient of the optometrist, a patient PMP report for the previous 12 months shall only be required when Schedules III or IV drugs are prescribed for a period greater than 10 days; and

(2) for an established patient during the continuous use of controlled substances, a PMP shall be requested a minimum of once every six months.

... .

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 17. Osteopathic Medicine and Surgery Practitioners
Part 5. Prescribing and Distribution of Controlled Substances

16.17.5. PRESCRIBING AND DISTRIBUTION OF CONTROLLED SUBSTANCES

16.17.5.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the New Mexico osteopathic medical board in requiring participation in the PMP is to assist practitioners in balancing the promotion of the safe use of controlled substances for the provision of medical care and services with the need to impede illegal and harmful activities involving these pharmaceuticals.

A. A health care practitioner who holds a federal drug enforcement administration registration and licensure to prescribe opioids shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A health care practitioner shall, before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when the patient is a new patient of the practitioner.
C. Prescription monitoring reports shall be requested and reviewed a minimum of once every six months during the continuous use of opioids for each established patient. The practitioner shall document the review of these reports.

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 19. Pharmacists
Part 4. Pharmacist
16.19.4. PHARMACIST

16.19.4.16 RESPONSIBILITIES OF PHARMACIST AND PHARMACIST INTERN:

E. Prescription monitoring report for opioid prescriptions. When presented with an opioid prescription for a patient, obtaining and reviewing a PMP report for that patient can be an important tool that assists the pharmacist in identifying issues or problems that put his or her patient at risk of prescription drug abuse or diversion. A pharmacist shall use professional judgment based on prevailing standards of practice in determining whether to obtain and review a PMP report before dispensing an opioid prescription to that patient, and shall document his or her action regarding such reports.

(1) A pharmacists shall request and review a PMP report covering at least a one year time period and another states’ report, where applicable and available if:

(a) a pharmacist becomes aware of a person currently exhibiting potential abuse or misuse of opioid (i.e. over-utilization, early refills, multiple prescribers, appears overly sedated or intoxicated upon presenting a prescription for an opioid or an unfamiliar patient requesting an opiate by specific name, street name, color, or identifying marks, or paying cash when the patient has prescription insurance);

(b) a pharmacist receives an opioid prescription issued by a prescriber with whom the pharmacist is unfamiliar (i.e., prescriber is located out-of-state or prescriber is outside the usual pharmacy geographic prescriber care area);

(c) a pharmacist receives an opioid prescription for an unfamiliar patient who resides outside the usual pharmacy geographic patient population area;

(d) a pharmacist receives an initial prescription for any long-acting opioid formulations, including oral and transdermal dosage forms (e.g. fentanyl or methadone);

(e) a pharmacist becomes aware of a patient receiving an opioid concurrently with a benzodiazepine or carisoprodol;

(2) The pharmacist shall document the review of these PMP reports.

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(3) Upon recognizing any of the above conditions prescribed in Paragraph (1) of Subsection E of 16.19.4.16 NMAC, a pharmacist, sing professional judgment, shall take appropriate steps to avoid or resolve the potential problem. These steps may include consulting with the prescriber and counseling the patient. The pharmacist shall document steps taken to resolve the potential problem.

(4) After obtaining an initial PMP report on a patient, a pharmacist shall use professional judgment base on prevailing standards of practice, in deciding the frequency of requesting and reviewing further prescription monitoring reports and other states’ reports for that patient. Except that PMP reports shall be reviewed a minimum of once every three months during the continuous use of opioids for each established patient. The pharmacist shall document the review of these reports.

(5) In the event a report is not immediately available, the pharmacist shall use professional judgment in determining whether it is appropriate and in the patient’s best interest to dispense the prescription prior to receiving a report.

16.19.4.17 PHARMACIST CLINCIAN:

F. Prescription monitoring program:
(1) A pharmacist clinician exercising prescriptive authority in the prescribing of a controlled substance;
(a) shall register with the board to become a regular participant in PMP inquiry and reporting;
(b) may authorize delegate(s) to access the PMP report consistent with 16.19.29 NMAC; while a pharmacist clinician's delegate may obtain a report from the states' PMP, a pharmacist clinician is solely responsible for reviewing the PMP report and documenting the receipt and review of a report in the patient's medical record;
(c) before a pharmacist clinician prescribes for the first time, a controlled substance in Schedule II, III or IV to a patient for a period greater than four days, or if there is a gap in prescribing the controlled substance for 30 days or more, the pharmacist clinician shall review a PMP report for the patient for the preceding 12 months; when available, the pharmacist clinician shall review similar reports from adjacent states; the pharmacist clinician shall document the receipt and review of such reports in the patient's medical record;
(d) a PMP report shall be;
(i) reviewed a minimum of once every three months during the continuous use of an opioid, benzodiazepine, or carisoprodol for each patient; and
(ii) reviewed a minimum of once every six months during the continuous use of a controlled substance in Schedule II, III or IV which is not an opioid, benzodiazepine, or carisoprodol for each patient; and
(iii) the pharmacist clinician shall document the review of these reports in the patient's medical record; nothing in this section shall be construed as preventing a pharmacist

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clinician from reviewing PMP reports with greater frequency than that required by this section;
(e) a pharmacist clinician does not have to obtain and review a PMP report before prescribing, ordering, or dispensing a controlled substance in Schedule II, III or IV;
(i) to a patient in a nursing facility; or
(ii) to a patient in hospice care.
(f) Upon review of a PMP report for a patient, the pharmacist clinician shall identify and be aware of a patient currently receiving:
(i) opioids from multiple prescribers;
(ii) opioids and benzodiazepines concurrently;
(iii) opioids for more than 12 consecutive weeks;
(iv) more than one controlled substance analgesic;
(v) opioids totaling more than 90 morphine milligram equivalents per day;
(vi) exhibiting potential for abuse of misuse of opioids and other controlled substances, such as overutilization, requests to fill early, requests for specific opioids, requests to pay cash when insurance is available, receiving opioids from multiple pharmacies.
(g) upon recognizing any of the above conditions described in Subparagraph (f) of Paragraph (1) of Subsection F of 16.19.4.17 NMAC, the pharmacist clinician using professional judgement based on prevailing standards of practice, shall take action as appropriate to prevent, mitigate, or resolve any potential problems or risks that may result in opioid misuse, abuse, or overdose; these steps may involve counseling the patient on known risks and realistic benefits of opioid therapy, prescription and training for naloxone, consultation with or referral to a pain management specialist, offering or arranging treatment for opioid or substance use disorder; the pharmacist clinician shall document actions taken to prevent, mitigate, or resolve the potential problems or risks.
(2) Pharmacist clinicians licensed to practice in an opioid treatment program, as defined in 7.32.8 NMAC, shall review a PMP report upon a patient's initial enrollment into the opioid treatment program and every three months thereafter while prescribing, ordering, administering, or dispensing opioid treatment medications in Schedule II for the purpose of treating opioid use disorder. The pharmacist clinician shall document the receipt and review of a report in the patient's medical record.

Code of New Mexico Rules (2016)
Title 16. Occupational and Professional Licensing
Chapter 21. Podiatrists
Part 9. Management of Pain with Controlled Substances

16.21.9. MANAGEMENT OF PAIN WITH CONTROLLED SUBSTANCES

16.21.9.10 PRESCRIPTION MONITORING PROGRAM (PMP) REQUIREMENTS: The intent of the New Mexico board of podiatry in requiring participation in the PMP is to assist practitioners in balancing the promotion of the safe use of controlled substances for the provision of medical care and services with the need to impede illegal and harmful activities involving these pharmaceuticals.
A. A podiatrist who holds a federal drug enforcement administration registration and a New Mexico controlled substance registration shall register with the board of pharmacy to become a regular participant in PMP inquiry and reporting.

B. A podiatrist shall, before prescribing, ordering, administering or dispensing a controlled substance listed in Schedule II, III or IV, obtain a patient PMP report for the preceding 12 months when one of the following situations exists:

(1) the patient is a new patient of the podiatrist, in which situation a patient PMP report for the previous 12 months shall only be required when Schedules II, III, and IV drugs are prescribed for a period greater than 10 days; and

(2) during the continuous use of opioids by established patients a PMP shall be requested and reviewed a minimum of once every six months.
NEW YORK

Public Health Law § 3343-a
10 ADC 80.63
14 ADC 822.16

McKinney's Consolidated Laws of New York Annotated (2016)
Public Health Law
Chapter 45. Of the Consolidated Laws
Article 33. Controlled Substances
Title IV. Dispensing to Ultimate Users

§ 3343-a. Prescription monitoring program registry

2. Duty to consult prescription monitoring program registry; practitioners. (a) Every practitioner shall consult the prescription monitoring program registry prior to prescribing or dispensing any controlled substance listed on schedule II, III or IV of section thirty-three hundred six of this article, for the purpose of reviewing a patient's controlled substance history as set forth in such registry; provided, however, that nothing in this section shall preclude an authorized practitioner, other than a veterinarian, from consulting the registry at his or her option prior to prescribing or dispensing any controlled substance. The duty to consult the registry shall not apply to:

(i) veterinarians;

(ii) a practitioner dispensing pursuant to subdivision three of section thirty-three hundred fifty-one of this article;

(iii) a practitioner administering a controlled substance;

(iv) a practitioner prescribing or ordering a controlled substance for use on the premises of an institutional dispenser pursuant to section thirty-three hundred forty-two of this title;

(v) a practitioner prescribing a controlled substance in the emergency department of a general hospital, provided that the quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use;

(vi) a practitioner prescribing a controlled substance to a patient under the care of a hospice, as defined by section four thousand two of this chapter;

(vii) a practitioner when:
(A) it is not reasonably possible for the practitioner to access the registry in a timely manner;
(B) no other practitioner or designee authorized to access the registry, pursuant to paragraph (b) of this subdivision, is reasonably available; and

(C) the quantity of controlled substance prescribed does not exceed a five day supply if the controlled substance were used in accordance with the directions for use;

(viii) a practitioner acting in compliance with regulations that may be promulgated by the commissioner as to circumstances under which consultation of the registry would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient;

(ix) a situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation; or

(x) a practitioner who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner, pursuant to a process established in regulation, and in the discretion of the commissioner.

Compilation of Codes, Rules and Regulations of the State of New York (2016)
Title 10. Department of Health
Chapter II. Administrative Rules and Regulations
Subchapter K. Controlled Substances
Part 80. Rules and Regulations on Controlled Substances
Prescribing and Dispensing Controlled Substances.

Section 80.63. Prescribing

(c) (1) Prior to prescribing for or dispensing to a patient any controlled substance listed on schedule II, III, or IV of section 3306 of the Public Health Law, every practitioner shall consult the prescription monitoring program registry for the purpose of reviewing that patient's controlled substance history. The patient's controlled substance history shall be obtained from the prescription monitoring program registry no more than 24 hours prior to the practitioner prescribing or dispensing any controlled substance to that patient. A practitioner shall document such consultation in the patient's medical chart or, if the practitioner does not consult the prescription monitoring program registry, the practitioner shall document in the patient's medical chart the reason such consultation was not performed. Such documentation shall include the specific exception listed in paragraph (2) of this subdivision.

(i) When such consultation is not performed due to circumstances specified in subparagraph (2)(vii) of this subdivision, the practitioner shall further document in the patient's medical chart the conditions, occurrences, or circumstances that caused such
consultation in a timely manner to be unreasonable. Such documentation shall include a
description of the barrier(s) to accessing the registry, and the efforts made by the
practitioner to contact other designees.

(ii) When such consultation is not performed due to circumstances specified in
subparagraph (2)(viii) of this subdivision, the practitioner shall further document in the
patient's medical chart a description of the circumstances supporting the practitioner's
conclusion that consultation of the registry would adversely impact the patient's ability to
obtain a prescription in a timely manner and the relationship between that delay and the
patient's medical condition.

(2) The duty to consult the prescription monitoring program registry shall not apply to:

(i) veterinarians;

(ii) a practitioner dispensing pursuant to Public Health Law section 3351(3);

(iii) a practitioner administering a controlled substance, as defined in Public Health Law
section 3302(2);

(iv) a practitioner prescribing or ordering a controlled substance pursuant to Public Health
Law section 3342(1) for a patient of an institutional dispenser as defined by Public Health
Law section 3302 for use on the premises of, or during an emergency transfer from, the
institutional dispenser;

(v) a practitioner prescribing a controlled substance in the emergency department of a
general hospital, provided that the quantity of controlled substance prescribed does not
exceed a five-day supply if the controlled substance were used in accordance with the
directions for use;

(vi) a practitioner prescribing a controlled substance to a patient under the care of a
hospice, as defined by Public Health Law section 4002;

(vii) a practitioner when:

(a) it is not reasonably possible for the practitioner to access the registry in a timely
manner;

(b) no other practitioner or designee authorized to access the registry, pursuant to Public
Health Law section 3343-a, is reasonably available; and

(c) the quantity of controlled substance prescribed does not exceed a five-day supply if the
controlled substance were used in accordance with the directions for use;

(viii) a practitioner acting in circumstances under which consultation of the registry would,
as determined by the practitioner, result in a patient's inability to obtain a prescription in a
timely manner, thereby adversely impacting the medical condition of such patient, provided that the quantity of the controlled substance does not exceed a five-day supply if the controlled substance were used in accordance with the directions for use;

(ix) a situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure as defined in section 80.64 of this Part. In the instance of a temporary technological or electrical failure, a practitioner shall, without undue delay, seek to correct any cause for the failure that is reasonably within his or her control; or

(x) a practitioner to whom the commissioner has granted a waiver from the requirement to consult the registry. A waiver may be issued by the commissioner based upon a showing by a practitioner that his or her ability to consult the registry in accordance with this section is unduly burdened by:

(a) technological limitations that are not reasonably within the control of the practitioner; or

(b) other exceptional circumstance demonstrated by the practitioner. The practitioner's showing shall include a sworn statement of facts detailing the circumstances in support of a waiver, and should be accompanied by any and all other information which would be relevant to the commissioner's determination. As part of the application for a waiver, the practitioner shall also provide any information which would tend to negate the need for a waiver. A waiver shall be granted by the commissioner for a specified period of time, but in no event for more than one year. Subsequent waivers shall be applied for in the same manner and shall be subject to the same requirements as the original waiver. A practitioner who has been granted a waiver shall notify the department in writing within five business days upon gaining the capability to consult the prescription monitoring program registry. Without regard to the original expiration date, the waiver granted to the practitioner shall terminate within a reasonable period of time as determined by the department, allowing for the practitioner to make accommodations to begin consulting the prescription monitoring program registry.

(3) A practitioner may authorize a designee to consult the prescription monitoring program registry on his or her behalf, provided that the ultimate decision as to whether or not to prescribe or dispense a controlled substance remains with the practitioner and is reasonably informed by the relevant controlled substance history information obtained from the registry. A practitioner may only appoint a designee if:

(i) such designee is located in the state of New York when accessing the prescription monitoring program registry;

(ii) the designee is employed by the same professional practice or is under contract with such practice. For purposes of this subparagraph, professional practice shall include, but not be limited to, an institutional dispenser where the designating practitioner is employed, under contract, or otherwise has privileges or authorization to practice;
(iii) the practitioner takes reasonable steps to ensure or has actual knowledge that such designee is sufficiently competent in the use of the registry and that such designee is aware of and conforms to all relevant Federal and State privacy statutes;

(iv) the practitioner remains responsible for ensuring that access to the registry by the designee is limited to authorized purposes and occurs in a manner that protects the confidentiality of the information obtained from the registry, and the practitioner remains responsible for any breach of confidentiality; and

(v) the practitioner selects and maintains all active designees authorized to access the prescription monitoring program registry in a format acceptable to the department. Upon a designee's relinquishment or termination of employment or authorization as a designee, a designating practitioner shall immediately notify the department, in a fashion deemed appropriate by the commissioner, of the revocation of the designee's authorization to access the prescription monitoring program registry on the designating practitioner's behalf.

(4) A pharmacist may consult the prescription monitoring program registry in order to review the controlled substance history of an individual for whom one or more prescriptions for controlled substances is presented to such pharmacist. A pharmacist may designate another pharmacist or a pharmacy intern as defined by section 6806 of the Education Law to consult the prescription monitoring program registry on the pharmacist's behalf, provided that:

(i) such designee is located in the state of New York when accessing the prescription monitoring program registry and is employed by the same pharmacy or is under contract with such pharmacy; and

(ii) the designating pharmacist selects and maintains all active designees authorized to access the prescription monitoring program registry in a format acceptable to the department. Upon relinquishment or termination of employment or authorization as a designee, a designating pharmacist shall immediately notify the department, in a fashion deemed appropriate by the commissioner, of the revocation of the designee's authorization to access the prescription monitoring program registry on the designating pharmacist's behalf.

(d) (1) No controlled substance prescription shall be issued prior to the examination of the patient by the practitioner except as otherwise permitted by this subdivision.

(2) Once the initial examination has been completed, the frequency and necessity for future examinations prior to prescribing, either for the same acute or chronic condition, will be made by the practitioner utilizing generally accepted medical standards, including taking into account the drug to be prescribed and the patient's condition, history and disposition toward the use of controlled substances.

(3) In the temporary absence of the initial prescriber, an authorized practitioner may issue a controlled substance prescription for a patient as part of a continuing therapy if the practitioner: (i) had direct access to the patient's medical records and such records warrant continued controlled substance prescribing, or (ii) had direct and adequate consultation with the initial
prescriber, who assures the necessity of continued controlled substance prescribing and with which the practitioner concurs. If the patient record is not available, the practitioner shall document the activity for his or her own record and shall transmit to the initial prescriber the prescription information. The initial prescriber shall include the prescription information in the patient's record.

(4) A practitioner may prescribe a controlled substance to his or her patient after review of the patient's record if the record contains the result of an examination performed by a consulting physician or hospital and such record warrants the prescribing.

(5) If a patient develops a new condition that would warrant the issuance of a prescription for a controlled substance, a practitioner may issue such prescription prior to performing an examination if: (i) the prescribing practitioner has a previously established practitioner/patient relationship with the patient; and (ii) an emergency exists; and (iii) the prescription does not exceed a 5 day supply as determined by the directions for use. An emergency means that the immediate administration of the drug is necessary for the proper treatment of the patient and that no alternative treatment is available. If the practitioner prescribes such substance orally, the practitioner must comply with the requirements of section 80.68 and section 80.70 of this Part.

Compilation of Codes, Rules and Regulations of the State of New York (2016)
Title 14. Department of Mental Hygiene
Chapter XXI. Office of Alcoholism and Substance Abuse Services
Part 822. General Service Standards for Chemical Dependence Outpatient (CD-OP) and Opioid Treatment Programs (Otp)

Section 822.16. Additional requirements for opioid treatment programs

(g) Opioid medical maintenance (OMM).

(1) **Patients admitted to OMM must meet specific criteria including:**

(i) four years of continuous treatment in an OTP;

(ii) three years of no drug abuse including alcohol;

(iii) three years of no criminal involvement;

(iv) three years of continuous gainful employment or productive activity;

(v) three years of emotional stability;

(vi) intent to continue maintenance treatment; and

(vii) **verified stability in the Prescription Monitoring Program ("PMP").**
NORTH CAROLINA

Per the state PDMP representative, North Carolina requires medical directors of opioid treatment programs to access the PMP database upon admission of a new patient and at least annually thereafter.
NORTH DAKOTA

§ 19-03.5-09
ADC 54-05-03.1-10
ADC 61-12-01-04
ADC 75-09.1-10-10

Title 19. Foods, Drugs, Oils, and Compounds
Chapter 19-03.5. Prescription Drug Monitoring Program

§ 19-03.5-09. Authority to adopt rules--Rules adopted by professional licensing boards

1. The state board of pharmacy may adopt rules that set forth the procedures and methods for implementing the prescription drug monitoring program under this chapter.

2. Each professional licensing board that is responsible for the licensing of individuals authorized to prescribe or dispense controlled substances for human consumption shall adopt rules under chapter 28-32 to require licensed individuals under that board’s jurisdiction who prescribe or dispense controlled substances to humans to utilize the prescription drug monitoring program. In drafting rules required under this subsection each professional licensing board shall consult with the state board of pharmacy, the other boards required to adopt rules under this subsection, and the advisory council in order to maximize the uniformity among the rules for each profession. All or any of the professional licensing boards subject to the rulemaking requirement of this subsection may conduct a joint rulemaking proceeding under chapter 28-32 to implement rules required by this subsection.

North Dakota Administrative Code (2016)
Title 54. Board of Nursing
Article 54-05. Standards of Practice
Chapter 54-05-03.1. Advanced Practice Registered Nurse

... 54-05-03.1-10. Authority to prescribe. The advanced practice registered nurse plans and initiates a therapeutic regimen that includes ordering and prescribing medical devices and equipment, nutrition, diagnostic and supportive services including home health care, hospice, and physical and occupational therapy.

... 4. An advanced practice registered nurse with prescriptive authority who prescribes controlled substances has access to the North Dakota prescription drug monitoring program and shall utilize the prescription drug monitoring program in the following manner:
a. Shall evaluate a prescription drug monitoring program report for a client in the following situations:
   (1) New or unestablished client requiring prescription for controlled substance;
   (2) Every six months during treatment of client with a controlled substance;
   (3) Client requests early refills or engages in a pattern of taking more than prescribed dosage; and
   (4) Upon suspicion or known drug overuse, diversion, or abuse by client.

b. Shall document evaluation of the prescription drug monitoring program reports made under this rule.

North Dakota Administrative Code (2016)
Title 61. State Board of Pharmacy
Article 61-12. Prescription Drug Monitoring Program
Chapter 61-12-01. Prescription Drug Monitoring Program

61-12-01-04. Required use for certain dispensing situations.

1. Prior to dispensing a prescription, each dispenser licensed by a regulatory agency in the state of North Dakota who dispenses a controlled substance to a patient, for the treatment of pain or anxiety shall, at a minimum, request and review a prescription drug monitoring report covering at least a one-year time period or another state's report, or both reports, when applicable and available, if the dispenser becomes aware of a person currently:

   a. Receiving reported drugs from multiple prescribers;

   b. Receiving reported drugs for more than twelve consecutive weeks;

   c. Abusing or misusing reported drugs (i.e., over-utilization; early refills; appears overly sedated or intoxicated upon presenting a prescription for a reported drug; or an unfamiliar patient requesting a reported drug by specific name, street name, color, or identifying marks);

   d. Requesting the dispensing of a reported drug from a prescription issued by a prescriber with whom the dispenser is unfamiliar (i.e., the prescriber is located out-of-state or the prescriber is outside the usual pharmacy geographic prescriber care area); or

   e. Presenting a prescription for reported drugs when the patient resides outside the usual pharmacy geographic patient population.

2. After obtaining an initial prescription drug monitoring report on a patient, a dispenser shall use professional judgment based on prevailing standards of practice in deciding the frequency of requesting and reviewing further prescription drug monitoring reports or other state's reports, or both reports, for that patient.

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3. In the rare event a report is not immediately available, the dispenser shall use professional judgment in determining whether it is appropriate and in the patient's best interest to dispense the prescription prior to receiving and reviewing a report.

4. For the purpose of compliance with subsection 1, a report could be obtained through a prescription drug monitoring program integration with software or also a board-approved aggregate tool, for which the NARxCHECK will be an approved tool. The national association of boards of pharmacy foundation's NARxCHECK service is a risk assessment tool for health care providers and pharmacists that accesses patient prescription information from prescription drug monitoring databases, analyzes the data, and provides a risk-based score that includes prescription drug monitoring program data and graphical analysis to assist in prescribing and dispensing decisions.

North Dakota Administrative Code (2016)
Title 75. Department of Human Services
Article 75-09.1. Substance Abuse Treatment Programs
Chapter 75-09.1-10. Licensing and Treatment Standards for Opioid Treatment Programs

75-09.1-10-10. Opioid treatment program administrative organization and responsibilities.

1. Each opioid treatment program shall develop a referral and consultative relationship with a network of agencies and providers capable of providing primary and specialty services for the range of behavioral difficulties, psychiatric comorbid conditions, medical complications, and communicable diseases that may be part of a patient's treatment needs. Any information exchanged across this network must facilitate treatment and protect patient privacy, consistent with the Health Insurance Portability and Accountability Act, and title 42, Code of Federal Regulations, part 2.

2. Each opioid treatment program shall create a written statement of its mission and goals for patient care.

3. An opioid treatment program shall maintain individualized personnel files as a record of employment. These files must contain employment and credentialing data, employment application data, date of employment, updated licensing and credentialing data, detailed job descriptions, performance evaluations, and appropriate training records.

4. An opioid treatment program shall require a criminal history record investigation as set forth under section 75-09.1-01-17 for an employee prior to allowing the employee to work with either adult or adolescent patients.

5. An opioid treatment program shall complete outcomes and data reports as requested by the division.

6. An opioid treatment program shall utilize the prescription drug monitoring program at least monthly for each patient.
OHIO

ADC 4729-5-20
§ 4731.055
ADC 4731-11-11
§ 4715.302
ADC 4715-6-01
§ 4723.487
ADC 4723-9-12
§ 4725.092
§ 4729.162
§ 4730.53
ADC 4723-6-21.4
ADC 4725-16-04
ADC 4730-2-10

Baldwin's Ohio Administrative Code (2016)
4729 Pharmacy Board
Chapter 4729-5. Pharmacy Practice--Administration

4729-5-20 Prospective drug utilization review

(A) Prior to dispensing any prescription, a pharmacist shall review the patient profile for the purpose of identifying:

(1) Over-utilization or under-utilization;

(2) Therapeutic duplication;

(3) Drug-disease state contraindications;

(4) Drug-drug interactions;

(5) Incorrect drug dosage;

(6) Drug-allergy interactions;

(7) Abuse/misuse;

(8) Inappropriate duration of drug treatment;

(9) Food-nutritional supplements-drug interactions.
(B) Upon recognizing any of the above, a pharmacist, using professional judgment, shall take appropriate steps to avoid or resolve the potential problem. These steps may include requesting and reviewing an OARRS report or another state’s report, pursuant to paragraph (D) of this rule, and/or consulting with the prescriber and/or counseling the patient.

(C) Prospective drug utilization review shall be performed using predetermined standards consistent with, but not limited to, any of the following:

1. Peer-reviewed medical literature (that is, scientific, medical, and pharmaceutical publications in which original manuscripts are rejected or published only after having been critically reviewed by unbiased independent experts);

2. American hospital formulary service drug information;

3. United States pharmacopoeia drug information;


(D) Prior to dispensing an outpatient prescription for a reported drug as listed in rule 4729-37-02 of the Administrative Code, at a minimum, a pharmacist shall request and review an OARRS report covering at least a one year time period, including a border state’s information when the pharmacist is practicing in a county bordering another state if that state’s information is available, in any of the following circumstances:

1. A patient adds a different or new reported drug to their therapy that was not previously included;

2. An OARRS report has not been reviewed for that patient during the preceding twelve months, as indicated in the patient profile;

3. A prescriber is located outside the usual pharmacy geographic area;

4. A patient is from outside the usual pharmacy geographic area;

5. A pharmacist has reason to believe the patient has received prescriptions for reported drugs from more than one prescriber in the preceding 3 months, unless the prescriptions are from prescribers who practice at the same physical location;

6. Patient is exhibiting signs of potential abuse or diversion. This includes, but is not limited to, over-utilization, early refills, appears overly sedated or intoxicated upon presenting a prescription for a reported drug, or an unfamiliar patient requesting a reported drug by specific name, street name, color, or identifying marks.
(E) In the rare event a report is not immediately available, the pharmacist shall use professional judgment in determining whether it is appropriate and in the patient’s best interest to dispense the prescription prior to receiving and reviewing a report.

(F) A pharmacist may use a delegate to request an OARRS report.

(G) A prescription, to be valid, must be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of his/her professional practice. The responsibility for the proper prescribing is upon the prescriber, but a corresponding responsibility rests with the pharmacist who dispenses the prescription. Based upon information obtained during prospective drug utilization review, a pharmacist shall use professional judgment when making a determination about the legitimacy of a prescription. A pharmacist is not required to dispense a prescription of doubtful, questionable, or suspicious origin.

Baldwin's Ohio Revised Code Annotated (2016)
Title XLVII. Occupations--Professions
Chapter 4731. Physicians; Limited Practitioners
State Medical Board

§ 4731.055 Conditions for prescribing certain drugs; review of patient information available through drug database

(A) As used in this section:

(1) “Drug database” means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(2) “Physician” means an individual authorized under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(3) “Opioid analgesic” and “benzodiazepine” have the same meanings as in section 3719.01 of the Revised Code.

(B) Except as provided in divisions (C) and (E) of this section, a physician shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine, or personally furnishing a complete or partial supply of such a drug, as part of a patient's course of treatment for a particular condition:

(1) Before initially prescribing or furnishing the drug, the physician or the physician's delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the physician practices primarily in a county of this state that adjoins another state, the physician or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.
(2) If the patient's course of treatment for the condition continues for more than ninety days after the initial report is requested, the physician or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the physician shall assess the information in the report. The physician shall document in the patient's record that the report was received and the information was assessed.

(C) Division (B) of this section does not apply in any of the following circumstances:

(1) A drug database report regarding the patient is not available, in which case the physician shall document in the patient's record the reason that the report is not available.

(2) The drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days.

(3) The drug is prescribed or personally furnished for the treatment of cancer or another condition associated with cancer.

(4) The drug is prescribed or personally furnished to a hospice patient in a hospice care program, as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill.

(5) The drug is prescribed or personally furnished for administration in a hospital, nursing home, or residential care facility.

(6) The drug is prescribed or personally furnished to treat acute pain resulting from a surgical or other invasive procedure or a delivery.

(D) The state medical board may adopt rules that establish standards and procedures to be followed by a physician regarding the review of patient information available through the drug database under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) This section and any rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.
4731-11-11 Standards and procedures for review of Ohio Automated Rx Reporting System (OARRS)

(A) For purposes of this rule:

(1) “Delegate” means an authorized representative who is registered with the Ohio board of pharmacy to obtain an OARRS report on behalf of a physician;

(2) “OARRS” means the “Ohio Automated Rx Reporting System” drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(3) “OARRS report” means a report of information related to a specified patient generated by the drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(4) “Personally furnish” means the distribution of drugs by a prescriber to the prescriber’s patients for use outside the prescriber’s practice setting.

(5) “Reported drugs” means all the drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained pursuant to section 4729.75 of the Revised Code, including controlled substances in schedules II, III, IV, and V.

(B) Standards of care:

(1) The accepted and prevailing minimal standards of care require that when prescribing or personally furnishing a reported drug, a physician shall take into account all of the following:

(a) The potential for abuse of the reported drug;

(b) The possibility that use of the reported drug may lead to dependence;

(c) The possibility the patient will obtain the reported drug for a nontherapeutic use or distribute it to other persons; and

(d) The potential existence of an illicit market for the reported drug.

(2) In considering whether a prescription for or the personally furnishing of a reported drug is appropriate for the patient, the physician shall use sound clinical judgment and obtain and review an OARRS report consistent with the provisions of this rule.

(C) A physician shall obtain and review an OARRS report to help determine if it is appropriate to prescribe or personally furnish an opioid analgesic, benzodiazepine, or reported drug to a patient as provided in this paragraph and paragraph (F) of this rule:
(1) A physician shall obtain and review an OARRS report before prescribing or personally furnishing an opiate analgesic or benzodiazepine to a patient, unless an exception listed in paragraph (G) of this rule is applicable.

(2) A physician shall obtain and review an OARRS report when a patient’s course of treatment with a reported drug other than an opioid analgesic or benzodiazepine has lasted more than ninety days, unless an exception listed in paragraph (G) of this rule is applicable.

(3) A physician shall obtain and review an OARRS report when any of the following red flags pertain to the patient:

(a) Selling prescription drugs;

(b) Forging or altering a prescription;

(c) Stealing or borrowing reported drugs;

(d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;

(e) Suffering an overdose, intentional or unintentional;

(f) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;

(g) Having been arrested, convicted, or received diversion or intervention in lieu of conviction for a drug related offense while under the physician’s care;

(h) Receiving reported drugs from multiple prescribers, without clinical basis;

(i) Traveling with a group of other patients to the physician’s office where all or most of the patients request controlled substance prescriptions;

(j) Traveling an extended distance or from out of state to the physician’s office;

(k) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient’s use of illegal or reported drugs;

(l) A known history of chemical abuse or dependency;

(m) Appearing impaired or overly sedated during an office visit or exam;

(n) Requesting reported drugs by street name, color, or identifying marks;

(o) Frequently requesting early refills of reported drugs;
(p) Frequently losing prescriptions for reported drugs;

(q) A history of illegal drug use;

(r) Sharing reported drugs with another person; or

(s) Recurring visits to non-coordinated sites of care, such as emergency departments, urgent care facilities, or walk-in clinics to obtain reported drugs.

(D) A physician who decides to utilize an opioid analgesic, benzodiazepine, or other reported drug in any of the circumstances within paragraphs (C)(2) and (C)(3) of this rule, shall take the following steps prior to issuing a prescription for or personally furnishing the opioid analgesic, benzodiazepine, or other reported drug:

(1) Review and document in the patient record the reasons why the physician believes or has reason to believe that the patient may be abusing or diverting drugs;

(2) Review and document in the patient’s record the patient’s progress toward treatment objectives over the course of treatment;

(3) Review and document in the patient record the functional status of the patient, including activities for daily living, adverse effects, analgesia, and aberrant behavior over the course of treatment;

(4) Consider using a patient treatment agreement including more frequent and periodic reviews of OARRS reports and that may also include more frequent office visits, different treatment options, drug screens, use of one pharmacy, use of one provider for the prescription or personally furnishing of reported drugs, and consequences for non-compliance with the terms of the agreement. The patient treatment agreement shall be maintained as part of the patient record; and

(5) Consider consulting with or referring the patient to a substance abuse specialist.

(E) Frequency for follow-up OARRS reports:

(1) For a patient whose treatment with an opioid analgesic or benzodiazepine lasts more than ninety days, a physician shall obtain and review and OARRS report for the patient at least every ninety days during the course of treatment, unless an exception listed in paragraph (G) of this rule is applicable.

(2) For a patient who is treated with a reported drug other than an opioid analgesic or benzodiazepine for a period lasting more than ninety days, the physician shall obtain and review and OARRS report for the patient at least annually following the initial OARRS report obtained and reviewed pursuant to paragraph (C)(2) of this rule until the course of treatment utilizing the reported drug has ended, unless an exception in paragraph (G) of this rule is applicable.
(F) When a physician or their delegate requests an OARRS report in compliance with this rule, a physician shall document receipt and review of the OARRS report in the patient record, as follows:

(1) Initial reports requested shall cover at least the twelve months immediately preceding the date of the request:

(2) Subsequent reports requested shall, at a minimum, cover the period from the date of the last report to present;

(3) If the physician practices primarily in a county of this state that adjoins another state, the physician or their delegate shall also request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county; and

(4) If an OARRS report regarding the patient is not available, the physician shall document in the patient’s record the reason that the report is not available and any efforts made in follow-up to obtain the requested information.

(G) A physician shall not be required to review and assess an OARRS report when prescribing or personally furnishing an opioid analgesic, benzodiazepine, or other reported drug under the following circumstances, unless a physician believes or has reason to believe that a patient may be abusing or diverting reported drugs:

(1) The reported drug is prescribed or personally furnished to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill;

(2) The reported drug is prescribed for administration in a hospital, nursing home, or residential care facility;

(3) The reported drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days;

(4) The reported drug is prescribed or personally furnished for the treatment of cancer or another condition associated with cancer; and

(5) The reported drug is prescribed or personally furnished to treat acute pain resulting from a surgical or other invasive procedure or a delivery.

Baldwin's Ohio Revised Code Annotated (2016)
Title XLVII. Occupations--Professions
Chapter 4715. Dentists; Dental Hygienists
Disciplinary Action; Prohibitions
§ 4715.302 Conditions for prescribing certain drugs; review of patient information available through drug database

(A) As used in this section:

(1) “Drug database” means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(2) “Opioid analgesic” and “benzodiazepine” have the same meanings as in section 3719.01 of the Revised Code.

(B) Except as provided in divisions (C) and (E) of this section, a dentist shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine, or personally furnishing a complete or partial supply of such a drug, as part of a patient's course of treatment for a particular condition:

(1) Before initially prescribing or furnishing the drug, the dentist or the dentist's delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the dentist practices primarily in a county of this state that adjoins another state, the dentist or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient's course of treatment for the condition continues for more than ninety days after the initial report is requested, the dentist or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the dentist shall assess the information in the report. The dentist shall document in the patient’s record that the report was received and the information was assessed.

(C)(1) Division (B) of this section does not apply if a drug database report regarding the patient is not available. In this event, the dentist shall document in the patient's record the reason that the report is not available.

(2) Division (B) of this section does not apply if the drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days.

(D) The state dental board may adopt rules that establish standards and procedures to be followed by a dentist regarding the review of patient information available through the
drug database under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) This section and any rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.

Baldwin's Ohio Administrative Code Annotated (2016)
4715 Dental Board
Chapter 4715-6. Automated Prescription Reporting System

4715-6-01 Standards and procedures for review of Ohio Automated Rx Reporting System (OARRS)

(A) For purposes of this rule and sections 4715.30 (A)(13) and 4715.302 of the Revised Code:

(1) “OARRS” means Ohio Automated Prescription Reporting System;

(2) “OARRS report” means a report of information related to a specific patient generated by the drug database established and maintained by the State board of pharmacy pursuant to section 4729.75 of the Revised Code.

(3) “Personally furnishing” does not include the administration of a drug.

(4) “Reported drugs” includes the following:

(a) All controlled substances in scheduled II, III, IV, and V; and

(b) All dangerous drug products containing carisoprodol or tramadol.

(5) “Diversion” includes but is not limited to the following:

(a) Selling drugs;

(b) Borrowing drugs;

(c) Sharing drugs.

(6) “Protracted basis” means for a period in excess of twelve continuous weeks, and for no more than twenty four weeks over a period of one year.

(B) If a dentist knows or has reason to believe that a patient may be abusing or diverting drugs, the dentist shall use sound clinical judgment in determining whether or not a reported drug should be prescribed or personally furnished to the patient under the circumstances. To assist in this determination, the dentist shall consider whether to access OARRS and document receipt and assessment of the information received if the patient exhibits signs of drug abuse or diversion. These signs may include, but are not limited to, the following:
(1) Engaging in or has a history of drug related criminal activity;

(2) Is receiving reported drugs from multiple prescribers;

(3) Has family members, friends, law enforcement officers, or health care professionals express concern related to the patient's use of illegal or reported drug;

(4) Has a known history of chemical abuse or dependency;

(5) Is requesting reported drugs by street name, color, or identifying marks;

(6) Frequently requesting early refills of reported drugs;

(7) Frequently losing prescriptions for reported drugs.

(C) Following review of OARRS report information, the dentist shall document receipt of the information in the patient's record.

(D) A dentist licensed under this chapter who prescribes or personally furnishes reported drugs to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report in the following circumstances:

(1) Once the dentist has reason to believe that treatment will be required on a protracted basis;

(2) At least once annually thereafter.

(E) In requesting OARRS reports according to this rule:

(1) Reports requested should cover a time period of at least one year;

(2) In the event an OARRS report is not immediately available prior to writing a prescription for, or personally furnishing, a reported drug, the dentist shall document in the patient record why the OARRS report was not available.

(F) Paragraph (D) above does not apply to a hospice patient in a hospice care program as those terms are defined in Section 3712.01 of the Revised Code.

Baldwin's Ohio Revised Code Annotated (2016)  
Title XLVII. Occupations--Professions  
Chapter 4723. Nurses  
Certificates to Prescribe  

§ 4723.487 Conditions for prescribing certain drugs; review of patient information available through drug database
(A) As used in this section:

(1) “Drug database” means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(2) “Opioid analgesic” and “benzodiazepine” have the same meanings as in section 3719.01 of the Revised Code.

(B) Except as provided in divisions (C) and (E) of this section, an advanced practice registered nurse holding a certificate to prescribe issued under this chapter shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine as part of a patient's course of treatment for a particular condition:

(1) Before initially prescribing the drug, the nurse or the nurse's delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the nurse practices primarily in a county of this state that adjoins another state, the nurse or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient's course of treatment for the condition continues for more than ninety days after the initial report is requested, the nurse or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the nurse shall assess the information in the report. The nurse shall document in the patient's record that the report was received and the information was assessed.

(C) Division (B) of this section does not apply if in any of the following circumstances:

(1) A drug database report regarding the patient is not available, in which case the nurse shall document in the patient's record the reason that the report is not available.
(2) The drug is prescribed in an amount indicated for a period not to exceed seven days.
(3) The drug is prescribed for the treatment of cancer or another condition associated with cancer.
(4) The drug is prescribed to a hospice patient in a hospice care program, as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill.
(5) The drug is prescribed for administration in a hospital, nursing home, or residential care facility.

(D) The board of nursing may adopt rules, in accordance with Chapter 119. of the Revised Code, that establish standards and procedures to be followed by an advanced practice registered nurse with a certificate to prescribe issued under section 4723.48 of the Revised Code regarding the review of patient information available through the drug database under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) This section and any rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.

Baldwin's Ohio Administrative Code Annotated (2016)
4723 Nursing Board
Chapter 4723-9. Prescriptive Authority

4723-9-12 Standards and procedures for review of OARRS

(A) Definitions; for purposes of this rule:

(1) “APRN” means a clinical nurse specialist, certified nurse mid-wife, or certified nurse practitioner who holds a current, valid certificate to prescribe issued by the board.

(2) “Delegate” means an authorized representative who is registered to obtain an OARRS report on behalf of an APRN.

(3) “OARRS” means the Ohio automated RX reporting system established and maintained according to section 4729.75 of the Revised Code.

(4) “OARRS report” means a report of information related to a specified patient generated by the drug database established maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(5) “Reported drugs” means all drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained according to section 4729.75 of the Revised Code, including controlled substance schedules II, III, IV and V.

(B) Standards of care: in addition to the requirements set forth in rule 4723-9-08 and rule 4723-9-09 of the Administrative Code, accepted and prevailing standards of care require that when prescribing or personally furnishing a reported drug, an APRN shall taking into account the potential for abuse of the reported drug, the possibility that the reported drug may lead to dependence, the possibility the patient will obtain the reported drug for a nontherapeutic use or distribute it to other persons, and the potential existence of an illicit market for the reported drug. When considering these circumstances in the course of determining whether to prescribe or personally furnish a reported drug to a patient, the APRN shall use sound clinical judgment and
consider obtaining and reviewing an OARRS report, consistent with the requirements of this rule.

(C) Red flags: an APRN shall obtain and review an OARRS report when any of the following red flags pertain to the patient:

1. Selling prescription drugs;
2. Forging or altering a prescription;
3. Stealing or borrowing reported drugs;
4. Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;
5. Suffering an overdose, intentional or nonintentional;
6. Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;
7. Having been arrested, convicted, or received diversion, or intervention in lieu of conviction for a drug-related offense while under the APRN’s care;
8. Receiving reported drugs from multiple prescribers, without clinical basis;
9. Traveling with a group of other patients to the APRN’s office, where all or most of the patients request controlled substances prescriptions;
10. Traveling an extended distance or from out of state to the APRN’s office;
11. Having a family member, friend, law enforcement officer or health care professional express concern related to the patient’s use of illegal or reported drugs;
12. A known history of chemical abuse or dependency;
13. Appearing impaired or overly sedated during an office visit or examination;
14. Requesting reported drugs by specific name, street name, color, or identifying marks;
15. Frequently requesting early refills of reported drugs;
16. Frequently losing prescriptions for reported drugs;
17. A history of illegal drug use;
18. Sharing reported drugs with another person; or
(19) Recurring visits to non-coordinated sites of care, such as emergency departments, urgent care facilities, or walk-in clinics to obtain reported drugs.

(D) OARRS review; opioid analgesics and benzodiazepines.

(1) Except as provided in paragraph (G) of this rule, an APRN shall:

(a) Obtain and review an OARRS report before initially prescribing to a patient a reported drug that is an opioid analgesic or benzodiazepine;

(b) If the patient continues to receive opioid analgesics or benzodiazepines for more than ninety days after the initial report is requested, the APRN shall obtain and review OARRS reports for the patient at intervals not exceeding ninety days, determined according to the date the initial request was made, and until the course of treatment has ended; and

(c) In obtaining and reviewing OARRS reports, comply with paragraph (F) of this rule.

(E) OARRS review; reported drugs that are not opioid analgesics or benzodiazepines.

(1) Except as provided in paragraph (G) of this rule, an APRN shall:

(a) Obtain and review an OARRS report following a course of treatment for a period of more than ninety days if the treatment includes the prescribing or personally furnishing of reported drugs that are not opioid analgesics or benzodiazepines;

(b) Obtain and review an OARRS report at least annually thereafter until the course of treatment utilizing these reported drugs has ended; and

(c) In obtaining and reviewing OARRS reports, comply with paragraph (F) of this rule.

(F) OARRS reports; time period; adjoining state: for purposes of paragraphs (C), (D), and (E) of this rule:

(1) OARRS reports may be requested by the APRN’s delegate but must be personally reviewed by the APRN;

(2) Receipt and assessment of the OARRS report information, including consultation with the collaborating physician that occurred based on the OARRS report information or as required by paragraph (H) of this rule, shall be documented in the patient record;

(3) Initial reports requested shall cover at least twelve months immediately preceding the date of the request;

(4) If the APRN practices in a county of this state that adjoins another state, the APRN or the APRN’s delegate shall also request a report of any information available in the drug
database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining the county; and

(5) If an OARRS report regarding the patient is not available, the APRN shall document in the patient’s record the reason that the report is not available and any efforts made in follow-up to obtain the requested information.

(G) OARRS report exceptions: an APRN shall not be required to review and assess an OARRS report when prescribing or personally furnishing a reported drug under the following circumstances, unless the APRN believes or has reason to believe that the patient may be abusing or diverting reported drugs:

(1) The reported drug is prescribed or personally furnished to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill;

(2) The reported drug is prescribed for administration in a hospital, nursing home, or residential care facility;

(3) The reported drug is prescribed or personally furnished in an amount indicated for a period not to exceed seven days; or

(4) The reported drug is prescribed for treatment of cancer or another condition associated with cancer.

(H) Physician consultation: an APRN who prescribes or personally furnishes a reported drug to a patient following review of an OARRS report under paragraphs (C), (D), or (E) of this rule, and determines, based on the OARRS report or red flags described in paragraph (C) of this rule that the patient may be abusing or diverting reported drugs, shall first consult with their collaborating physician prior to personally furnishing or prescribing a reported drug at the patient’s next visit.

(1) Consultation shall include and result in:

(a) Review and documentation of the reasons why the APRN believes or has reason to believe that the patient may be abusing or diverting drugs;

(b) Review and documentation of the patient’s progress toward treatment objectives over the course of treatment; and

(c) Review and documentation of the functional status of the patient, including activities for daily living, adverse effects, analgesia and aberrant behavior over the course of treatment.

(2) Consultation may include and result in:

(a) Utilization of a patient treatment agreement that includes more frequent and periodic review of OARRS reports, more frequent office visits, different treatment options, drug screens, use of
one pharmacy, use of one provider for the prescription or personally furnishing of reported drugs, and consequences for non-compliance with the terms of the agreement. The patient treatment agreement shall be maintained as part of the patient record; and

(b) Consultation with or referral to a substance use disorder specialist.

Baldwin's Ohio Revised Code Annotated (2016)
Title XLVII. Occupations--Professions
Chapter 4725. Optometrists; Dispensing Opticians
State Board of Optometry

§ 4725.092 Conditions for prescribing certain drugs; review of patient information available through drug database

(A) As used in this section “drug database” means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(B) The state board of optometry shall adopt rules that establish standards and procedures to be followed by an optometrist who holds a therapeutic pharmaceutical agents certificate regarding the review of patient information available through the drug database under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(C) This section and the rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.

Baldwin's Ohio Revised Code Annotated (2016)
Title XLVII. Occupations--Professions
Chapter 4729. Pharmacists; Dangerous Drugs
Registration of Pharmacists

§ 4729.162 Review of patient information available through drug database

(A) As used in this section, “drug database” means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(B) The state board of pharmacy shall adopt rules in accordance with Chapter 119 of the Revised Code that establish standards and procedures to be followed by a pharmacist regarding the review of patient information available through the drug database under division (A)(6) of section 4729.80 of the Revised Code.

(C) This section and the rules adopted under it do not apply if the board no longer maintains the drug database.
Chapter 4730. Physician Assistants

§ 4730.53 Conditions for prescribing certain drugs; review of patient information available through drug database

(A) As used in this section:

(1) “Drug database” means the database established and maintained by the state board of pharmacy pursuant to section 4729.75 of the Revised Code.

(2) “Opioid analgesic” and “benzodiazepine” have the same meanings as in section 3719.01 of the Revised Code.

(B) Except as provided in divisions (C) and (E) of this section, a physician assistant licensed under this chapter who has been granted physician-delegated prescriptive authority shall comply with all of the following as conditions of prescribing a drug that is either an opioid analgesic or a benzodiazepine as part of a patient’s course of treatment for a particular condition:

(1) Before initially prescribing the drug, the physician assistant or the physician assistant’s delegate shall request from the drug database a report of information related to the patient that covers at least the twelve months immediately preceding the date of the request. If the physician assistant practices primarily in a county of this state that adjoins another state, the physician assistant or delegate also shall request a report of any information available in the drug database that pertains to prescriptions issued or drugs furnished to the patient in the state adjoining that county.

(2) If the patient’s course of treatment for the condition continues for more than ninety days after the initial report is requested, the physician assistant or delegate shall make periodic requests for reports of information from the drug database until the course of treatment has ended. The requests shall be made at intervals not exceeding ninety days, determined according to the date the initial request was made. The request shall be made in the same manner provided in division (B)(1) of this section for requesting the initial report of information from the drug database.

(3) On receipt of a report under division (B)(1) or (2) of this section, the physician assistant shall assess the information in the report. The physician assistant shall document in the patient’s record that the report was received and the information was assessed.

(C) Division (B) of this section does not apply in any of the following circumstances:

(1) A drug database report regarding the patient is not available, in which case the physician assistant shall document in the patient’s record the reason that the report is not available.

(2) The drug is prescribed in an amount indicated for a period not to exceed seven days.
(3) The drug is prescribed for the treatment of cancer or another condition associated with cancer.

(4) The drug is prescribed to a hospice patient in a hospice care program, as those terms are defined in section 3712.01 of the Revised Code, or any other patient diagnosed as terminally ill.

(5) The drug is prescribed for administration in a hospital, nursing home, or residential care facility.

(D) The state medical board may adopt rules that establish standards and procedures to be followed by a physician assistant licensed under this chapter who has been granted physician-delegated prescriptive authority regarding the review of patient information available through the drug database under division (A)(5) of section 4729.80 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

(E) This section and any rules adopted under it do not apply if the state board of pharmacy no longer maintains the drug database.

Baldwin's Ohio Administrative Code Annotated (2016)
4123 Workers' Compensation Bureau
Chapter 4123-6. Health Partnership Program (HPP)

4123-6-21.4 Coordinated services program

. . .

(D) Pharmacies participating in the bureau’s CSP.

. . .

(2) Pharmacies participating in the bureau’s CSP agree to perform the following monitoring activities:

(a) For each injured worker in the bureau’s CSP for whom the pharmacy is the designated pharmacy, the pharmacy shall conduct a bimonthly review of the injured worker’s OARRS report from the Ohio board of pharmacy (or a similar automated prescription monitoring report from the injured worker’s state of residence).

(b) The pharmacy shall notify the injured worker’s prescribing physician of any critical findings discovered in the report. Critical findings are indications of any prescription related activity that could cause harm to the patient, including but not limited to:

(i) Duplication of therapy,

(ii) Excessive doses of concurrent medications,
(iii) Potential drug interactions or potentiation of side effects.

(c) The pharmacy shall notify BWC in writing whenever reports are made under paragraph (D)(2)(b) of this rule.

(d) BWC may request quarterly documentation of the pharmacy’s monitoring activities under paragraphs (D)(2)(a) to (D)(2)(d) of this rule.

...
(1) To assist in this determination, the optometrist shall access OARRS and document receipt and assessment of the information received if the patient exhibits the following signs of drug abuse or diversion:

(a) Selling prescription drugs;
(b) Forging or altering a prescription;
(c) Stealing or borrowing reported drugs;
(d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;
(e) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;
(f) Having been arrested, convicted or received diversion, or intervention in lieu of conviction for a drug related offense while under the physician's care;
(g) Receiving reported drugs from multiple prescribers, without clinical basis; or
(h) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient's use of illegal or reported drugs.

(2) Other signs of possible abuse or diversion which may necessitate accessing OARRS include, but are not limited to the following:

(a) A known history of chemical abuse or dependency;
(b) Appearing impaired or overly sedated during an office visit or exam;
(c) Requesting reported drugs by specific name, street name, color, or identifying marks;
(d) Frequently requesting early refills of reported drugs;
(e) Frequently losing prescriptions for reported drugs;
(f) A history of illegal drug use;
(g) Sharing reported drugs with another person; or
(h) Recurring emergency department visits to obtain reported drugs.

(C) An optometrist prescribing or personally furnishing reported drugs to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report in the following circumstances:
(1) Once the optometrist has reason to believe that the treatment will be required on a protracted basis; and

(2) At least once annually, thereafter.

(D) An optometrist shall document receipt and assessment of all OARRS reports in the patient record.

(1) Initial reports requested in compliance with this rule shall cover a time period of at least one year;

(2) Subsequent reports requested in compliance with this rule shall, at a minimum, cover the period from the date of the last report to present.

(E) In the event an OARRS report is not available prior to writing a prescription for a reported drug or personally furnishing the reported drug, an optometrist shall document in the patient record why the OARRS report was not available.

(F) Paragraph (C) of this rule does not apply to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code.

Baldwin's Ohio Administrative Code Annotated (2016)
4730 Physician Assistants
Chapter 4730-2. Prescriptive Authority

4730-2-10. Standards and procedures for review of “Ohio Automated Rx Reporting System” (OARRS).

(A) For purposes of this rule:

(1) “OARRS” means the “Ohio Automated Rx Reporting System” drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(2) “OARRS report” means a report of information related to a specified patient generated by the drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(3) “Personally furnish” means the distribution of drugs by a prescriber to the prescriber’s patients for use outside the prescriber’s practice setting.

(4) “Protracted basis” means a period in excess of twelve continuous weeks.

(5) “Reported drugs” means all the drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained pursuant to section 4729.75 of the Revised Code, including:
(a) Controlled substances in schedules II, III, IV, and V, and

(b) All dangerous drug products containing tramadol.

(B) If a physician assistant believes or has reason to believe that a patient may be abusing or diverting drugs, the physician assistant shall use sound clinical judgment in determining whether or not the reported drug should be prescribed to the patient under the circumstances.

(1) To assist in this determination, the physician assistant shall access OARRS and document receipt and assessment of the information received if the patient exhibits the following signs of drug abuse or diversion:

(a) Selling prescription drugs;

(b) Forging or altering a prescription;

(c) Stealing or borrowing reported drugs;

(d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;

(e) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;

(f) Having been arrested, convicted or received diversion, or intervention in lieu of conviction for a drug related offense while under the physician’s care;

(g) Receiving reported drug from multiple prescribers, without clinical basis; or

(h) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient’s use of illegal or reported drugs.

(2) Other signs of possible use or diversion which may necessitate accessing OARRS include, but are not limited to the following:

(a) A known history of chemical abuse or dependency;

(b) Appearing impaired or overly sedated during an office visit or exam;

(c) Requesting reported drugs by specific name, street name, color, or identifying marks;

(d) Frequently requesting early refills of reported drugs;

(e) Frequently losing prescriptions for reported drugs;

(f) A history of illegal drug use;
(g) Sharing reported drugs with another person; and

(h) Recurring emergency department visits to obtain reported drugs.

(C) A physician assistant prescribing reported drugs to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report in the following circumstances:

(1) Once the physician assistant has reason to believe that the treatment will be required on a protracted basis; and

(2) At least once annually, thereafter.

(D) A physician assistant shall document receipt and assessment of all OARRS reports in the patient record.

(1) Initial reports requested in compliance with this rule shall cover a time period of at least one year;

(2) Subsequent reports requested in compliance with this rule shall, at a minimum, cover the period from the date of the last report to present.

(E) In the event an OARRS report is not available prior to writing a prescription for a reported drug or personally furnishing the reported drug, the physician assistant shall document in the patient record why the OARRS report was not available.

(F) Paragraph (C) of this rule does not apply to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code.

(G) Review of the physician assistant’s compliance with this rule shall be included as an activity in the quality assurance plan required by division (F) of section 4730.21 of the Revised Code.
OKLAHOMA

63 § 2-302
63 § 2-309D

Oklahoma Statutes Annotated (2016)
Title 63. Public Health and Safety
Chapter 2. Uniform Controlled Dangerous Substances Act
Article III. Regulation of Manufacture, Distribution, Dispensing, Prescribing, Administering and Using for Scientific Purposes of Controlled Dangerous Substances
Registration

§ 2-302. Registration requirements

A. Every person who manufactures, distributes, dispenses, prescribes, administers or uses for scientific purposes any controlled dangerous substance within this state, or who proposes to engage in the manufacture, distribution, dispensing, prescribing, administering or use for scientific purposes of any controlled dangerous substance within this state shall obtain a registration issued by the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control, in accordance with rules promulgated by the Director. Persons registered by the Director under Section 2-101 et seq. of this title to manufacture, distribute, dispense, or conduct research with controlled dangerous substances may possess, manufacture, distribute, dispense, or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of this article. Every wholesaler, manufacturer or distributor of any drug product containing pseudoephedrine or phenylpropanolamine, or their salts, isomers, or salts of isomers shall obtain a registration issued by the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control in accordance with rules promulgated by the Director and as provided for in Section 2-332 of this title.

. . .

M. Beginning November 1, 2010, each registrant that prescribes, administers or dispenses methadone shall be required to check the prescription profile of the patient on the central repository of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control.

Oklahoma Statutes Annotated (2016)
Title 63. Public Health and Safety
Chapter 2. Uniform Controlled Dangerous Substances Act
Article III. Regulation of Manufacture, Distribution, Dispensing, Prescribing, Administering and Using for Scientific Purposes of Controlled Dangerous Substances
Anti-Drug Diversion Act

§ 2-309D. Central repository information--Confidentiality--Access--Disclosure--Penalties—Liability

. . .

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G. Registrants shall have access to the central repository for the purposes of patient treatment and for determination in prescribing or screening new patients. The patient’s history may be disclosed to the patient for the purposes of treatment of information at the discretion of the physician.

2. a. Prior to prescribing or authorizing for refill, if one hundred eighty (180) days have elapsed prior to the previous access and check, of opiates, synthetic opiates, semisynthetic opiates, benzodiazepine or carisoprodol to a patient of record, registrants or members of their medical or administrative staff shall be required until October 31, 2020, to access the information in the central repository to assess medical necessity and the possibility that the patient may be unlawfully obtaining prescription drugs in violation of the Uniform Controlled Dangerous Substances Act. The duty to access and check shall not alter or otherwise amend appropriate medical standards of care. The registrant or medical provider shall note in the patient file that the central repository has been checked and may maintain a copy of the information.

b. The requirements set forth in subparagraph a of this paragraph shall not apply:

(1) to medical practitioners who prescribe the controlled substances set forth in subparagraph a of this paragraph for hospice or end-of-life care, or

(2) for a prescription of a controlled substance set forth in subparagraph a of this paragraph that is issued by a practitioner for a patient residing in a nursing facility as defined by Section 1-1902 of this title, provided that the prescription is issued to a resident of such facility.

3. Registrants shall not be liable to any person for any claim of damages as a result of accessing or failing to access the information in the central repository and no lawsuit may be predicated thereon.

...
PENNSYLVANIA

35 § 872.8
§ 403

Purdon's Pennsylvania Statutes and Consolidated Statutes (2016)
Title 35 P.S. Health and Safety
Chapter 6B. Drugs, Poisons and Dangerous Substances
Achieving Better Care by Monitoring All Prescriptions Program (Abc-Map) Act

§ 872.7. Requirements for dispensers and pharmacies.

(e) System query.--
(1) A dispenser shall query the system before dispensing an opioid drug product or a benzodiazepine prescribed to a patient if any of the following apply:
   (i) the patient is a new patient of the dispenser.
   (ii) the patient pays cash when they have insurance.
   (iii) the patient requests a refill early.
   (iv) the patient is getting opioid drug products or benzodiazepines from more than one prescriber.
(2) For the purposes of this subsection, a new patient does not include an individual going to the same pharmacy, or a different physical location of that pharmacy, if the patient's record is available to the dispenser.

§ 872.8. Requirements for prescribers

(a) System query.--A prescriber shall query the system:

(1) for each patient the first time the patient is prescribed a controlled substance by the prescriber for purposes of establishing a base line and a thorough medical record;

(2) if a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs; or

(3) each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber.

(a)(1) Query not required.—If a patient has been admitted to a licensed health care facility or is in observation status in a licensed health care facility, the prescriber does not need to query the system after the initial query under subsection (a)(1) as long as the patient remains admitted to the licensed health care facility or remains in observation status in a licensed health care facility.

…
(b) Medical record entries.--A prescriber shall indicate the information obtained from the system in the patient's medical record if:

(1) the individual is a new patient; or

(2) the prescriber determines a drug should not be prescribed or furnished to a patient based upon the information from the system.

(c) Prescriber designee.--Prescribers may designate employees for purposes of accessing the system according to standards established by the board. In assigning a designee, a prescriber shall give preference to a professional nurse licensed by the State Board of Nursing.

(d) Nonviolation.--A prescriber or dispenser who, in the exercise of sound clinical judgment, does not believe that a patient is abusing or diverting controlled substances shall not be in violation of this act for not seeking or obtaining information from the system prior to prescribing or dispensing so long as the prescriber or dispenser is otherwise in compliance.

. . .

Purdon’s Pennsylvania Statutes and Consolidated Statutes
Title ___.
Chapter ____.
Medical Marijuana Program.
§ 403. Issuance of certification.

(a) Conditions for issuance. – A certification to use medical marijuana may be issued by a practitioner to a patient if all of the following requirements are met:

(1) The practitioner has been approved by the department for inclusion in the registry and has a valid, unexpired, unrevoked, unsuspended Pennsylvania license to practice medicine at the time of the issuance of the certification.

(2) The practitioner has determined that the patient has a serious medical condition and has included the condition in the patient’s health care record.

(3) The patient is under the practitioner’s continuing care for the serious medical condition.

(4) In the practitioner’s professional opinion and review of past treatments, the practitioner determines the patient is likely to receive therapeutic or palliative benefit from the use of medical marijuana.

(b) Contents. – The certification shall include:

(1) The patient’s name, date of birth and address.

(2) The specific serious medical condition of the patient.
(3) A statement by the practitioner that the patient has a serious medical condition and the patient is under the practitioner’s continuing care for the serious medical condition.

(4) The date of issuance.

(5) The name, address, telephone number and signature of the practitioner.

(6) Any requirement or limitation concerning the appropriate form of medical marijuana and limitation on the duration of use, if applicable, including whether the patient is terminally ill.

(c) Consultation. – A practitioner shall review the prescription drug monitoring program prior to:

(1) Issuing a certification to determine the controlled substance history of the patient.

(2) Recommending a change of amount or form of medical marijuana.

(c.1) Other access by practitioner. – A practitioner may access the prescription drug monitoring program to do any of the following:

(1) Determine whether a patient may be under treatment with a controlled substance by another physician or other person.

(2) Allow the practitioner to review the patient’s controlled substance history as deemed necessary by the practitioner.

(3) Provide to the patient, or caregiver on behalf of the patient if authorized by the patient, a copy of the patient’s controlled substance history.

(d) Duties of practitioner. – The practitioner shall:

(1) Provide the certification to the patient.

(2) Provide a copy of the certification to the department, which shall place the information in the patient directory within the department’s electronic database. The department shall permit electronic submission of the certification.

(3) File a copy of the certification in the patient’s health care record.

(e) Prohibition. – A practitioner may not issue a certification for the practitioner’s own use or for the use of a family or household member.
RHODE ISLAND

§ 21-28-3.20
§ 21-28-3.32
S.B.2823A as amended 2016
ADC 46-1-13:45.0
ADC 31-2-6:3.0

General Laws of Rhode Island Annotated
Title 21. Food and Drugs
Chapter 28. Uniform Controlled Substances Act
Article III. Regulation of Manufacturing, Distributing, Prescribing, Administering, and Dispensing Controlled Substances

21-28-3.20. Authority of practitioner to prescribe, administer, and dispense. (a) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, and dispense controlled substances, or he or she may cause the controlled substances to be administered by a nurse or intern under his or her direction and supervision.

(b) The prescription monitoring program shall be reviewed prior to starting any opioid. A prescribing practitioner, or designee as authorized by §21-28-3.32(a)(3), shall review the prescription monitoring program prior to refilling or initiating opioid therapy with an intrathecal pump. For patients the prescribing practitioner is maintaining on continuous opioid therapy for pain for three (3) months or longer, the prescribing practitioner shall review information from the prescription monitoring program at least every three (3) months. Documentation of that review shall be noted in the patient’s medical record.


(m) The prescription monitoring program shall be reviewed prior to starting any opioid. A prescribing practitioner, or designee as authorized by subsection (a)(3) of this section, shall review the prescription monitoring program prior to refilling or initiating opioid therapy with an intrathecal pump. For patients the prescribing practitioner is maintaining on continuous opioid therapy for pain for three (3) months or longer, the prescribing practitioner shall review information from the prescription monitoring program at least every three (3) months. Documentation of that review shall be noted in the patient’s medical record.

Rhode Island Administrative Code (2016)
Title 46. Mental Health Retardation & Hospitals Department
Division 1. General
Rule 13. Rules and Regulations for the Licensing Behavioral Healthcare Organizations
Part VI. Services and Programs

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46-1-13:45.0. Opioid Treatment Programs

This section applies to all public or private opioid treatment and maintenance programs. These programs must also comply with all applicable sections of the General Regulations and with 42 CFR Part 8 (DHHS/SAMHSA, DEA Regulations), and Rhode Island General Laws section 21-28-1 et seq. (Uniform Controlled Substance Act), Rhode Island General Laws section 21-28.2-1 et seq. (Drug Abuse Control Act), Rhode Island General Laws section 21-28.3-1 et seq. (Drug Abuse Reporting System), Rhode Island General Laws section 5-19-1 et seq. (Pharmacy Statute), and Rhode Island State Methadone Authority. Programs shall reference the State Methadone Treatment Guidelines/ TIP1 (Treatment Improvement Protocol Series/CSAT) and Buprenorphine Treatment Guidelines.

45.4.5 A physical health assessment, including a medical history and physical examination, shall be completed within the first twenty-four (24) hours of a person's admission to the program.

A. This assessment shall include: an assessment of the possibility of: infectious diseases, including HIV, TB, Viral Hepatitis and sexually transmitted diseases; pulmonary, liver, and cardiac abnormalities; dermatological and neurological consequences of addiction; and possible concurrent surgical problems.

B. The assessment shall include laboratory tests, the results of which must be returned no later than fourteen (14) days after admission. The licensee shall ensure that such laboratory tests are completed by licensed facilities which shall comply with all applicable federal and state laboratory licensure and certification requirements. The laboratory tests shall include the following:

1. Tests to determine liver function;

2. Complete blood count and lipid panel; and

3. Screening test for syphilis.

C. If the Medical Director determines that laboratory tests are not clinically indicated at the time of admission, this justification shall be documented in the patient record.

D. Programs are required to check Department of Health's Prescription Monitoring Program for each new admission.

45.16 OTP's shall develop policies and procedures that ensure compliance with federal and state regulations before take-home medication privileges are granted. In addition, prior to advancement to a new take-home phase, programs are required to check the Department of Health's Prescription Monitoring Program. The policies and procedures shall, at a minimum, include the following:
45.16.1 The following treatment schedule shall be implemented:

A. At least a two (2) month probationary period with daily doses of medication ingested under appropriate supervision. During this time the individual must satisfactorily meet all requirements of the program. In the event that a program is closed on a Sunday or Holiday during a patient's two (2) month probationary period, if the patient meets the criteria established by the program and approved by the State Opioid Treatment Authority, the patient may receive one (1) take-home during this period. Written closure requests to the State Opioid Treatment Authority (as required in section 45.3 of these regulations) shall also include written detailed plans containing: patient inclusion/exclusion criteria, patient notification, diversion control, a documented history of take-home safety, and the submission of exception requests. Documentation of appropriateness shall be noted in the patient record.

B. During the first ninety (90) days of take-home privileges, the take-home supply shall be limited to a single dose each week. The individual shall ingest all other doses under appropriate supervision.

C. During the second ninety (90) days, the take-home supply shall be limited to two (2) doses per week.

D. During the third ninety (90) days, the take-home supply shall be limited to three (3) doses per week with no more than two (2) consecutive days supply of medication.

E. After one (1) year the individual may be permitted to reduce attendance to two (2) visits weekly and may be given no more than three (3) consecutive days supply of medication.

F. After two (2) years, the individual may be permitted to reduce program attendance to once weekly and may receive no more than six (6) days take-home supply of medication.

G. After three (3) years, the individual may be permitted to reduce program attendance to two (2) visits monthly and receive no more than a fourteen (14) day supply of medication.

H. After four (4) years, the individual may be permitted to reduce program attendance to once monthly. OTPs are required to inform the State Opioid Treatment Authority of all individuals advanced to this take-home phase.

45.16.2 In an emergency situation or severe illness, individuals may be given up to ten (10) days supply of medication based on the judgment of the OTP physician.

45.16.3 Prior to the initiation of take-home privileges, the following shall be confirmed and documented:

A. The individual shall receive instructions regarding safety. Such instructions shall include but not be limited to, child safety measures and the storage of medications.

B. The individual shall obtain an agency approved locked box for storage of take-home medication.
45.16.4 Take-home containers shall be labeled with the following:

A. Individual's name;
B. Name and amount of medication;
C. Directions for use, including route of administration;
D. Date issued and date medication is to be taken;
E. Program name and address;
F. Program's telephone number.

45.16.5 Childproof caps shall be used on all take-home bottles of opioid replacement medication.

45.16.6 The OTP physician shall document in the treatment record the rationale for authorizing take-home privileges.

45.16.7 The individuals shall return all take-home containers on their next day of Program attendance. Prior to the person's receiving his or her subsequent dose, bottles shall be inspected to ensure that they are coming from the appropriate person during the appropriate time-period.

45.16.8 The agency shall have a policy regarding the non-return of take-home bottles that includes the inter-ventions to be taken. Should there be a violation of this policy, the documentation required for each incident shall include the following:

A. The person's treatment history at the agency
B. Reason for damage to the label on the container or the person's inability to produce the container
C. Number of repeated occurrences.

45.16.9 Take-home privileges are not allowed during long or short-term opioid detoxification.

45.16.10 Take-home privileges may be revoked by the OTP physician with the rationale documented in the person's treatment record.

45.16.11 Individuals may contest a revocation of take-home privileges through the Concern and Complaint Resolution Procedure.

45.16.12 An OTP must maintain a Diversion Control Plan to ensure quality care while minimizing the diversion of an opioid replacement medication from treatment to illicit use. The plan shall include, but not be limited to, the following:

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A. Clinical and administrative continuous monitoring

B. Problem identification, correction, and prevention

C. Accountability to the person and to the community

45.16.13 When buprenorphine is given as a take-home medication, the medically indicated formulation shall be used.

West’s Rhode Island Administrative Code (2016)
Title 31. Health Department
Division 2. Drug Control
Rule 6. Rules and Regulations for Pain Management, Opioid Use and the Registration of Distributors of Controlled Substances in Rhode Island

31-2-6:3.0. Pain Management and Prescribing

3.5 The prescription monitoring program (PMP) shall be reviewed prior to starting any opioid.

3.7 Periodic Review. Periodic reviews, including an in-person visit, shall take place at intervals not to exceed twelve (12) months.

(a) During the periodic review, the practitioner shall determine:

(1) Patient’s adherence with any medication treatment plan;

(2) If pain, function, or quality of life have improved or diminished using objective evidence; and

(3) If continuation or modification of medications for pain management treatment is necessary based on the practitioner’s evaluation of progress towards treatment objectives.

(b) The practitioner shall consider tapering, changing, or discontinuing treatment when:

(1) Function or pain does not improve after a trial period; or

(2) There is reason to believe there has been misuse, addiction, or diversion.

(c) For patients the practitioner is maintaining on continuous opioid therapy for pain for six (6) months or longer, the practitioner shall review information from the prescription
monitoring program (PMP) at least every twelve (12) months. Documentation of that review shall be noted in the patient’s medical record.

3.13 Intrathecal Pump and the Use of Chronic Opioids.

(a) A practitioner shall review the prescription monitoring program (PMP) prior to refilling or initiating opioid therapy with an intrathecal pump.
§ 53-10-310
ADC 1140-11-.06
ADC 1200-34-01-.07
ADC 0940-05-42-.07
ADC 0940-05-42-.15
ADC 0940-05-42-.17

West’s Tennessee Code Annotated (2016)
Title 53. Food, Drugs and Cosmetics
Chapter 10. Legend Drugs

§ 53-10-310. Electronic access to controlled substance database; penalty

(e)(1) When prescribing a controlled substance, all healthcare practitioners, unless otherwise exempted under this part, shall check the controlled substance database prior to prescribing one (1) of the controlled substances identified in subdivision (e)(4) to a human patient at the beginning of a new episode of treatment and shall check the controlled substance database for that human patient at least annually when that prescribed controlled substance remains part of the treatment. An authorized healthcare practitioner’s delegate may check the controlled substance database on behalf of the healthcare practitioner. A new episode of treatment means a prescription for a controlled substance that has not been prescribed by that healthcare practitioner within the previous twelve (12) months.

(2) When dispensing a controlled substance, all healthcare practitioners, unless otherwise exempted under this part, shall check the controlled substance database prior to dispensing one (1) of the controlled substances identified in subdivision (e)(4) to a human patient the first time that patient is dispensed a controlled substance at that practice site. The dispenser shall check the controlled substance database again at least once every twelve (12) months for that human patient after the initial dispensing. The initial dispensing check fulfills the first annual check. An authorized healthcare practitioner’s delegate may check the controlled substance database on behalf of the healthcare practitioner.

(3) Before prescribing or dispensing, a healthcare practitioner shall have the professional responsibility to check the database or have a healthcare practitioner delegate check the database if the healthcare practitioner is aware or reasonably certain that a person is attempting to obtain a Schedule II-V controlled substance, identified by the committee as demonstrating a potential for abuse for fraudulent, illegal, or medically inappropriate purposes, in violation of § 53-11-402.

(4) The controlled substances which trigger a check of the controlled substance database pursuant to subdivisions (e)(1) and (2) include, but are not limited to, all opioids and...
benzodiazepines. By rule, the commissioner, pursuant to § 53-10-311, may require a check of the database for additional Schedule II-V controlled substances that are identified by the committee or commissioner as demonstrating a potential for abuse.

(5) The commissioner, pursuant to § 53-10-311, shall adopt rules in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, that establish standards and procedures to be followed by a healthcare practitioner regarding the review of patient information available through the database.

(6) Healthcare practitioners are not required to check the controlled substance database before prescribing or dispensing one (1) of the controlled substances identified in subdivision (e)(4) or added to that list by the committee or commissioner if one (1) or more of the following conditions is met:

(A) The controlled substance is prescribed or dispensed for a patient who is currently receiving hospice care;

(B) The committee has determined that healthcare practitioners in a particular medical specialty shall not be required to check the database as a result of the low potential for abuse by patients receiving treatment in that medical specialty;

(C) The quantity of the controlled substance which is prescribed or dispensed does not exceed an amount which is adequate for a single, seven-day treatment period and does not allow a refill; or

(D) The controlled substance is prescribed for administration directly to a patient during the course of inpatient or residential treatment in a hospital or nursing home licensed under title 68.

(f) Each appropriate licensure board may promulgate rules pursuant to the Uniform Administrative Procedures Act, to establish procedures, notice requirements, and penalties for healthcare practitioners who fail to register in, report to, or check the controlled substance database as required.

(g) Notwithstanding any other provision of this part to the contrary, a healthcare practitioner or healthcare practitioner delegate shall not be in violation of this part during any time period in which the controlled substance database is suspended or not operational or the Internet is not operational or available as defined by rules promulgated by the commissioner.

Tennessee Rules and Regulations (2016)
1140. Board of Pharmacy
Chapter 1140-11. Controlled Substance Monitoring Database

1140-11-.06 PRESCRIBER AND DISPENSER RESPONSIBILITIES (EFFECTIVE APRIL 1, 2013).
(1) All prescribers or their designated healthcare practitioner's extenders, unless otherwise exempted by T.C.A. Title 53, Chapter 10, part 3, shall check the database prior to prescribing one of the controlled substances identified below in paragraph (3) to a human patient at the beginning of a new episode of treatment and shall check the database for the human patient at least annually when that prescribed controlled substance remains part of treatment.

(2) Before dispensing, a dispenser shall have the professional responsibility to check the database or have a healthcare practitioner extender check the database, if the dispenser is aware or reasonably certain, that a person is attempting to obtain a Schedule II-V controlled substance, identified by the Committee as demonstrating a potential for abuse for fraudulent, illegal, or medically inappropriate purposes, in violation of T.C.A. § 53-11-402.

(3) The controlled substances which trigger a check of the database pursuant to paragraph (1) above include, but are not limited to, all opioids and benzodiazepines.

(4) Prescribers are not required to check the database before prescribing or dispensing one of the controlled substances identified in paragraph (3) above or added to that list by the Committee if one (1) or more of the following conditions is met:

(a) The controlled substance is prescribed or dispensed for a patient who is currently receiving hospice care;

(b) The Committee has determined that prescribers in a particular medical specialty shall not be required to check the database as a result of the low potential for abuse by patients receiving treatment in that medical specialty;

(c) The controlled substance is prescribed or dispensed to a patient as a non-refillable prescription as part of treatment for a surgical procedure that occurred in a licensed healthcare facility;

(d) The quantity of the controlled substance which is prescribed or dispensed does not exceed an amount which is adequate for a single, seven-day treatment period and does not allow a refill.

Tennessee Rules and Regulations (2016)
1200. Department of Health, Department of Environment and Conservation, and Department of Finance and Administration
1200-34. Division of Pain Management Clinics
Chapter 1200-34-01. Pain Management Clinics

1200-34-01-.07 MEDICAL DIRECTOR RESPONSIBILITIES.
(1) Clinic Operation and Personnel.

(a) The medical director of a pain management clinic shall:

1. oversee all of the pain management services provided at the clinic;

2. be on-site at the clinic at least twenty percent (20%) of the clinic's weekly total number of operating hours;

3. ensure that each supervising physician for each of the health care providers working at the clinic complies with the supervision requirements contained in Tenn. Comp. Rules and Regulations Chapter 0880-03 and Chapter 0880-06, or Rule 1050-02-.15, as applicable. Should the medical director of the clinic serve as a health care provider's supervising physician, the medical director must ensure that he or she complies with Chapter 0880-03 and Chapter 0880-06, or Rule 1050-02-.15, as applicable;

4. ensure that all health care providers employed by or working at the pain management clinic comply with applicable state and federal laws and rules relative to the prescribing of controlled substances in the pain management clinic;

5. ensure the establishment of protocols for the health care providers employed by or working at the pain management clinic as provided in Tenn. Comp. Rules and Regulations Chapter 0880-03 and Chapter 0880-06 and ensure that providers comply with such protocols, as well as any other established policies and procedures;

6. ensure that, in the event that the medical director for the clinic is unable to fulfill his or her duties on a temporary basis because of illness, vacation, or unavailability, there is an alternate or substitute medical director meeting the same qualifications as a medical director under 1200-34-01-.09;

7. establish quality assurance policies and procedures, which, at a minimum, include, but are not limited to:

(i) documentation of the background, training, licensure, and certifications for all pain management clinic staff providing patient care;

(ii) a written drug screening policy and compliance plan for patients to include random urine drug screening as clinically indicated, but at a minimum, upon each new admission and once every six (6) months thereafter;

(iii) use of substance abuse risk assessment tools upon new patient admission and periodic review or re-assessment;

(iv) evaluating and monitoring the quality and appropriateness of patient care, the methods of improving patient care as well as identifying and correcting deficiencies, and the opportunities to improve the clinic's performance and quality of care;
(v) medication counts for any controlled substances prescribed by the clinic to the clinic's patients;

(vi) use of patient agreements and periodic review of such agreements;

(vii) health care provider access to and review of patient information contained in the controlled substance monitoring database in accordance with T.C.A. §§ 53-10-301 - 53-10-309, as clinically indicated, but at a minimum upon each new admission and once every six (6) months thereafter;

(viii) documentation of requests for records from other health care providers;

... Tennesse Rules and Regulations (2016)
0940. Department of Mental Health and Developmental Disabilities
0940-05. Office of Licensure
Chapter 0940-05-42. Minimum Program Requirements for Non-Residential Opioid Treatment Program Facilities

0940-05-42-.07 SERVICE RECIPIENT RECORD REQUIREMENTS.

(2) The Facility shall document that the following assessments are completed prior to the development of the Individualized Program Plan (IPP).

(a) Screening. The sources and methods of verification shall have been recorded in the prospective service recipient's case folder. The screening process shall include:

1. Verification, to the extent possible, of a prospective service recipient's identity, including name, address, date of birth and other identifying data.

2. Drug history and current status, including determination and substantiation, to the extent possible, of the duration of substance dependence, determination by medical examination performed by a program physician of dependence on opium, morphine, heroin or any derivative or synthetic drug of that group, and determination of current Diagnostic and Statistical Manual (DSM) diagnosis.

3. Medical history, including past and family medical history, HIV status, pregnancy, a six-month history of prescriber medications, over-the-counter medications used frequently, and the patterns of specific usage of alcohol or other drugs for the past 30 days, and active medical problems.

4. Verification of other prescribed controlled medications through the PMP.

5. Psychiatric history and current mental status exam.
6. Within 14 days of admission, physical assessment and laboratory tests, including drug screens, HIV status, if the prospective service recipient consents to be tested, pregnancy, sexually transmitted diseases, Mantoux tuberculosis tests, Hepatitis C, and others as directed by the SOTA.

7. Pregnancy tests for females at admission and at least annually thereafter, unless otherwise indicated.

8. Determination if the prospective service recipient needs special services, such as treatment for alcoholism or psychiatric services, and determination that the Facility is capable of addressing these needs either directly or through referral.

9. If a prospective service recipient is 18 years of age or older, verification of dependence on opium, morphine, heroin or any derivative or synthetic drug of that group for a period of two years or verification of one year of opioid dependence and one documented unsuccessful attempt at clinical treatment. If clinically appropriate, the program physician may waive these dependency and detoxification requirements for service recipients released from penal institutions (within six months after release), for pregnant service recipients with a verified pregnancy and for previously treated service recipients.

10. If a prospective service recipient is under 18 years of age, verification of two documented unsuccessful attempts at detoxification within a twelve month period. Additionally, no person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian or responsible adult designated by the SOTA consents in writing to such treatment.

. . .

Tennessee Rules and Regulations (2016)
0940. Department of Mental Health and Developmental Disabilities
0940-05. Office of Licensure
Chapter 0940-05-42. Minimum Program Requirements for Non-Residential Opioid Treatment Program Facilities

0940-05-42-.15 MEDICATION MANAGEMENT.

. . .

(c) Take-home doses of methadone or buprenorphine shall be handled in accordance with applicable rules of the Substance Abuse and Mental Health Administration or other applicable federal agency.

1. All requests for take-home exceptions shall be reviewed and approved by the SOTA and any other applicable federal agency.

2. The Facility shall check the PMP database prior to requesting any take-home or dosing exceptions and shall submit this report to the SOTA with the exception request.
3. The Facility shall provide counseling prior to providing take-home doses to any service recipient. Progress notes in the service recipient's record shall document the counseling provided.

4. The Facility shall document in the service recipient's record the basis for approving “take-home” medication for the service recipient. The following criteria shall be considered in determining the service recipient's eligibility for “take-home” medications.

(i) Cessation of illicit drug use;

(ii) Regularity of program attendance;

(iii) Length of time and level of treatment in medication therapy (ability to responsibly self-medicate);

(iv) Absence of known recent criminal activity (especially drug dealing);

(v) Absence of serious behavioral problems;

(vi) Absence of abuse of drugs including excessive use of alcohol;

(vii) Other special needs of the service recipient, such as split dosing, physical health needs, pain treatment, etc.;

(viii) Capacity to safely store “take-home” medication within the service recipient's home;

(ix) Stability of the home environment and social relationships;

(x) Service recipient's work, school, or other daily-life activity schedule; and

(xi) Hardship experienced by the service recipient in traveling to and from the Facility.

. . .

(h) The Facility shall check the PMP database upon admission of the service recipient, at least every six months to determine if controlled substances other than methadone are being prescribed for the service recipient, and thereafter as clinically indicated. The service recipient's record shall include documentation of the check of the PMP database and the date upon which it occurred.

. . .

Tennessee Rules and Regulations (2016)
0940. Department of Mental Health and Developmental Disabilities
0940-05. Office of Licensure
Chapter 0940-05-42. Minimum Program Requirements for Non-Residential Opioid Treatment Program Facilities

0940-05-42-.17 DRUG SCREENS.

(17) The Facility shall access the PMP:

(a) Upon admission of a service recipient;

(b) Before the initial administration of methadone or other treatment in an opioid treatment program;

(c) After any positive drug test for prescription medication;

(d) Every six months to determine if controlled substances other than methadone are being prescribed for the service recipient. The service recipient's record shall include documentation of the check of the PMP database and the date upon which it occurred; and

(e) Each PMP access shall confirm that the service recipient is not seeking prescription medication from multiple sources.

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TEXAS

22 TAC 170.3

Texas Administrative Code (2016)
Title 22. Examining Boards
Part 9. Texas Medical Board
Chapter 170. Pain Management

§ 170.3. Minimum Requirements for the Treatment of Chronic Pain

A physician’s treatment of a patient’s pain will be evaluated by considering whether it meets the generally accepted standard of care and whether the following minimum requirements have been met:

(1) Evaluation of the patient.

(A) A physician is responsible for obtaining a medical history and a physical examination that includes a problem-focused exam specific to the chief presenting complaint of the patient.

(B) The medical record shall document the medical history and physical examination. In the case of chronic pain, the medical record must document:

(i) the nature and intensity of the pain;

(ii) current and past treatments for pain;

(iii) underlying or coexisting diseases and conditions;

(iv) the effect of the pain on physical and psychological function;

(v) any history and potential for substance abuse or diversion; and

(vi) the presence of one or more recognized medical indications for the use of a dangerous or scheduled drug.

(C) Prior to prescribing dangerous drugs or controlled substances for the treatment of chronic pain, a physician must consider reviewing prescription data and history related to the patient, if any, contained in the Prescription Drug Monitoring Program described by §§481.075, 481.076, and 481.0761 of the Texas Health and Safety Code and consider obtaining at a minimum a baseline toxicology drug screen to determine the presence of drugs in a patient, if any. If a physician determines that such steps are not necessary prior to prescribing dangerous drugs or controlled substances to the patient, the physician must document in the medical record his or her rationale for not completing such steps.

(A) The physician must see the patient for periodic review at reasonable intervals in view of the individual circumstances of the patient.

(B) Periodic review must assess progress toward reaching treatment objectives, taking into consideration the history of medication usage, as well as any new information about the etiology of the pain.

(C) Each periodic visit shall be documented in the medical records.

(D) Contemporaneous to the periodic reviews, the physician must note in the medical records any adjustment in the treatment plan based on the individual medical needs of the patient.

(E) A physician must base any continuation or modification of the use of dangerous and scheduled drugs for pain management on an evaluation of progress toward treatment objectives.

(i) Progress or the lack of progress in relieving pain must be documented in the patient’s record.

(ii) Satisfactory response to treatment may be indicated by the patient’s decreased pain, increased level of function, and/or improved quality of life.

(iii) Objective evidence of improved or diminished function must be monitored. Information from family members or other caregivers, if offered or provided, must be considered in determining the patient’s response to treatment.

(iv) If the patient’s progress is unsatisfactory, the physician must reassess the current treatment plan and consider the use of other therapeutic modalities.

(v) The physician must periodically review the patient’s compliance with the prescribed treatment plan and reevaluate for any potential for substance abuse or diversion. In such a review, the physician must consider reviewing prescription data and history related to the patient, if any, contained in the Prescription Drug Monitoring Program described by §§481.075, 481.076, and 481.0761 of the Texas Health and Safety Code and consider obtaining at a minimum a toxicology drug screen to determine the presence of drugs in a patient, if any. If a physician determines that such steps are not necessary, the physician must document in the medical record his or her rationale for not completing such steps.

...
§ 58-37f-303
§ 58-31b-803
H.B.375 2016

West’s Utah Code Annotated (2015)
Title 58. Occupations and Professions
Chapter 37F. Controlled Substance Database Act
Part 3. Access


(1) As used in this section:

(a) “Dispenser” means a licensed pharmacist, as described in Section 58-17b-303, or a pharmacist’s licensed intern, as described in Section 58-17b-304, who is also licensed to dispense a controlled substance under Title 58, Chapter 37, Utah Controlled Substances Act.

(b) “Opioid” means those substances listed in Subsection 58-37-4(2)(b)(i) or (2)(b)(ii).

(c) “Outpatient” means a setting in which an individual visits a licensed healthcare facility or a healthcare provider’s office for a diagnosis or treatment but is not admitted to a licensed healthcare facility for an overnight stay.

(d) “Prescriber” means an individual authorized to prescribe a controlled substance under Title 58, Chapter 37, Utah Controlled Substances Act.

(2) To address the serious public health concern of life-altering and life-threatening opioid abuse and overdose, and to achieve the purposes of this chapter and as described in Section 58-37f-201, which includes identifying and reducing the prescribing and dispensing of opioids in an unprofessional or unlawful manner or in quantities or frequencies inconsistent with generally recognized standards of dosage for an opioid, through utilization of the carefully developed and highly respected database;

(a) a prescriber or dispenser of an opioid for individual outpatient usage shall access and review the database as necessary in the prescriber’s or dispenser’s professional judgment and to achieve the purpose of this chapter as described in Section 58-37f-201;

(b) a prescriber may assign the access and review required under Subsection (2)(a) to an employee, in accordance with Subsections 58-37f-301(2)(g) and (h).

(3) The division shall, in collaboration with the licensing boards for prescribers and dispensers:

(a) develop a system that gathers and reports to prescribers and dispensers the progress and results of the prescriber’s and dispenser’s individual access and review of the database, as provided in this section; and
(b) reduce or waive the division’s continuing education requirements regarding opioid prescriptions, described in Section 58-37-6.5, including the online tutorial and test relating to the database, for prescribers and dispensers whose individual utilization of the database contribute to the life-saving and public safety purposes of this section and as described in Subsection (2).

(4) If the dispenser’s access and review of the database suggest that the individual seeking an opioid may be obtaining opioids in quantities or frequencies inconsistent with generally recognized standards as provided in this section and Section 58-37f-201, the dispenser shall reasonably attempt to contact the prescriber to obtain the prescriber’s informed, current, and professional decision regarding whether the prescribed opioid is medically justified, notwithstanding the results of the database search.

Utah Code Annotated (2015)
Title 58. Occupations and Professions
Chapter 31B. Nurse Practice Act
Part 8. Practice Standards

§ 58-31b-803. Prescriptive authority for advanced practice nurses – Schedule II controlled substance or device – Workers’ compensation – Pain clinics

(1) This section does not apply to an advanced practice registered nurse specializing as a certified registered nurse anesthetist under Subsection 58-31b-102(14)(d).

(2) Except as provided in Subsection (3), an advanced practice registered nurse shall prescribe or administer a Schedule II controlled substance in accordance with a consultation and referral plan.

(3) Except as provided by Subsection 58-31b-502(18), an advanced practice registered nurse may prescribe or administer a Schedule II controlled substance without a consultation and referral plan if the advanced practice registered nurse:

(a) has the lesser of:

(i) two years of licensure as a nurse practicing advanced practice registered nursing; or

(ii) 2,000 hours of experience practicing advanced practice registered nursing;

(b)(i) prior to the first time prescribing or administering a Schedule III controlled substance for chronic pain, or a Schedule II controlled substance to a particular patient, unless treating the patient in a licensed general acute hospital, checks information about the patient in the Controlled Substance Database created in Section 58-37f-201; and

(ii) periodically, thereafter, checks information about the patient in the Controlled Substance Database created in Section 58-37f-201; and
(c) follows the health care provider prescribing guidelines for the treatment of an injured worker, developed by the Labor Commission under Title 34A, Chapter 2, Workers’ Compensation Act, or Title 34A, Chapter 3, Utah Occupational Disease Act, if:

(i) the patient is an injured worker; and

(ii) the Schedule II or III controlled substance is prescribed for chronic pain.
VERMONT

18 § 4289
18 § 4290
ADC 12-5-21:6.0
ADC 12-5-50:4.0
ADC 12-5-53:5.0
ADC 12-5-53:7.0
ADC 12-5-53:8.0
ADC 12-5-102:2
ADC 12-7-5:7502
S.B. 243 2016

Vermont Statutes Annotated (2016)
Title Eighteen. Health
Part 5. Foods and Drugs
Chapter 84A. Vermont Prescription Monitoring System

§ 4289. Standards and guidelines for health care providers and dispensers

(a) Each professional licensing authority for health care providers shall develop evidence-based standards to guide health care providers in the appropriate prescription of Schedules II, III, and IV controlled substances for treatment of acute pain, chronic pain, and for other medical conditions to be determined by the licensing authority. The standards developed by the licensing authorities shall be consistent with rules adopted by the Department of Health. The licensing authorities shall submit their standards to the Commissioner of Health, who shall review for consistency across health care providers and notify the applicable licensing authority of any inconsistencies identified.

(b)(1) Each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the VPMS by November 15, 2013.

(2) If the VPMS shows that a patient has filled a prescription for a controlled substance written by a health care provider who is not a registered user of VPMS, the Commissioner of Health shall notify the applicable licensing authority and the provider by mail of the provider’s registration requirement pursuant to subdivision (1) of this subsection.

(3) The Commissioner of Health shall develop additional procedures to ensure that all health care providers who prescribe controlled substances are registered in compliance with subdivision (1) of this subsection.

(c) Except in the event of electronic or technological failure, health care providers shall query the VPMS with respect to an individual patient in the following circumstances:
(1) at least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance;

(2) when starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more;

(3) the first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain; and

(4) prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance pursuant to section 4290 of this title.

(d)(1) Each dispenser who dispenses any Schedule II, III, or IV controlled substances shall register with the VPMS.

(2) Except in the event of electronic or technological failure, dispensers shall query the VPMS in accordance with rules adopted by the Commissioner of Health.

<Text of section (d)(3) effective 30 days after notice and a determination by the Commissioner of Health that daily reporting is practicable>

(3) Pharmacies and other dispensers shall report each dispensed prescription for a Schedule II, III, or IV controlled substance to the VPMS within 24 hours or one business day after dispensing.

(e) The Commissioner of Health shall, after consultation with the Controlled Substances and Pain Management Advisory Council, adopt rules necessary to effect the purposes of this section. The Commissioner and the Council shall consider additional circumstances under which health care providers should be required to query the VPMS, including whether health care providers should be required to query the VPMS prior to writing a prescription for any opioid Schedule II, III, or IV controlled substance or when a patient requests renewal of a prescription for an opioid Schedule II, III, or IV controlled substance written to treat acute pain, and the Commissioner may adopt rules accordingly.

(f) Each professional licensing authority for health care providers and dispensers shall consider the statutory requirements, rules, and standards adopted pursuant to this section in disciplinary proceedings when determining whether a licensee has complied with the applicable standard of care.

Vermont Statutes Annotated (2016)
Title Eighteen. Health
Part 5. Foods and Drugs
Chapter 84A. Vermont Prescription Monitoring System

§ 4290. Replacement prescriptions and medications
(a) As used in this section, “replacement prescription” means an unscheduled prescription request in the event that the document on which a patient's prescription was written or the patient's prescribed medication is reported to the prescriber as having been lost or stolen.

(b) When a patient or a patient's parent or guardian requests a replacement prescription for a Schedule II, III, or IV controlled substance, the patient's health care provider shall query the VPMS prior to writing the replacement prescription to determine whether the patient may be receiving more than a therapeutic dosage of the controlled substance.

(c) When a health care provider writes a replacement prescription pursuant to this section, the provider shall clearly indicate as much by writing the word “REPLACEMENT” on the face of the prescription. The health care provider shall document the writing of the replacement prescription in the patient's medical record.

Vermont Administrative Code (2016)
Title 12. Agency of Human Services
Subtitle 5. Department of Health
General
Rule 21. Prescription Monitoring System

12-5-21:6.0. Requirements for Prescribers.

6.1 Registering with the VPMS

The following professionals and entities must register with the Department to enable their access to the VPMS system:

6.1.1 All Vermont prescribers of controlled substances and their delegates

6.1.2 The Medical Director of the Department of Vermont Health Access

6.1.3 Health care providers licensed to practice in a state with an active reciprocal agreement for Prescription Monitoring Program data-sharing

6.1.4 Health care providers licensed to practice in another state who treat Vermont patients

6.1.5 Vermont’s Chief Medical Examiner, and delegate, and medical examiners licensed to practice in another state investigating the death of a Vermont resident

6.2 Required Querying of VPMS

Prior to prescribing a controlled substance for a patient, Vermont licensed prescribers and/or their delegates must query the VPMS system in the following circumstances:
6.2.1 “The first time the provider prescribes an opioid Schedule II, III, or IV controlled substance written to treat chronic pain;” 18 V.S.A. § 4289 (d)(3).

6.2.2 “When starting a patient on a Schedule II, III, or IV controlled substance for nonpalliative long-term pain therapy of 90 days or more;” 18 V.S.A. § 4289 (d)(2).

6.2.3 “Prior to writing a replacement prescription for a Schedule II, III, or IV controlled substance.” 18 V.S.A. § 4289 (d)(4).

6.2.4 “At least annually for patients who are receiving ongoing treatment with an opioid Schedule II, III, or IV controlled substance;” 18 V.S.A. § 4289 (d)(1).

6.2.5 When prescribing Schedule II, III or IV controlled substances to treat acute pain for a duration longer than 21 days.

6.2.6 In addition, in an Emergency Department or Urgent Care setting:

6.2.6.1 When a patient requests an opioid prescription for chronic pain from an Emergency Department or Urgent Care prescriber if the prescriber intends to write a prescription for an opioid.

6.2.6.2 When a patient requests an extension of a current opioid prescription for acute pain from an Emergency Department or Urgent Care prescriber if the prescriber intends to write a prescription for an opioid.

6.2.6.3 Before prescribing an opioid for longer than 10 days.

6.2.7 Prior to prescribing buprenorphine or a drug containing buprenorphine to a Vermont patient for the first time and at regular intervals thereafter, and:

6.2.7.1 No fewer than two times annually thereafter.

6.2.7.2 Prior to writing a replacement prescription.

6.2.8 Prior to prescribing buprenorphine or a drug containing buprenorphine that exceeds the dosage threshold approved by the Vermont Medicaid Drug Utilization Review Board and published in its Preferred Drug List, prescribers must receive prior approval from the Chief Medical Officer or Medical Director of the Department of Vermont Health Access or designee.

6.3 Delegates

Prescribers may designate a delegate or delegates to access and query the VPMS system subject to Section 7.2 of this rule.

Vermont Administrative Code (2016)

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Title 12. Agency of Human Services
Subtitle 5. Department of Health
General
Rule 50. Rules Governing the Prescription of Extended Release Hydrocodone Manufactured Without Abuse-Deterrent Formulations.

12-5-50:4.0. Prescription of Extended Release Hydrocodones without ADFs

Prior to prescribing an extended release hydrocodone that is manufactured without an ADF, the prescriber shall:

4.1 Conduct and document a thorough medical evaluation and physical examination as part of the patient's medical record;

4.2 Evaluate and document relative risks and benefits for the individual patient of the use of hydrocodones that are manufactured without an ADF prior to writing a prescription for such a hydrocodone. The evaluation shall include but not be limited to a Risk Assessment as defined in Section 3.3;

4.3 Document in the medical record that the prescription of a hydrocodone without an ADF is required for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options, including non-pharmacological treatments, are ineffective, not tolerated, or would otherwise be inadequate to provide sufficient management of pain;

4.4 Receive a signed Informed Consent form from the patient, or if the patient is not competent to provide informed consent, from the patient's legal representative, that shall include information regarding the drug's potential for addiction, abuse, and misuse; and the risks associated with the drug of life-threatening respiratory depression; overdose as a result of accidental exposure potentially fatal especially in children; neonatal opioid withdrawal symptoms; and potentially fatal overdose when interacting with alcohol;

4.5 Receive a signed Controlled Substance Treatment Agreement from the patient that shall include requirements such as urine screening (no less frequent than every 120 days), pill counts, safe storage and disposal, and other appropriate conditions as determined by the prescriber to reasonably and timely inform the prescriber if the patient is misusing the prescribed substance;

4.6 Query the Vermont Prescription Monitoring System (VMPS) and review other controlled substances prescribed to the patient prior to the first prescription. For any patient prescribed 40 mg or greater per day, the prescriber shall query the VPMS no less frequently than once every 120 days for as long as the patient possesses a valid prescription for that amount;

4.7 Determine a maximum daily dose, or a "not to exceed value" for the prescription to be transmitted to the pharmacy;
4.8 Write a prescription that must be filled within seven (7) days and that does not exceed 30 days in duration;

4.8 Schedule and undertake periodic follow-up visits and evaluations.

Vermont Administrative Code (2016)
Title 12. Agency of Human Services
Subtitle 5. Department of Health
General
Rule 53. Prescribing of Opioids for Chronic Pain

12-5-53:5.0. Prescribing Opioids for Chronic Pain.

5.1 Prior to prescribing an opioid for the treatment of chronic pain, the prescriber shall consider and document in the patient’s medical record:

5.1.1 Non-opioid alternatives up to a maximum recommended by the FDA, including non-pharmacological treatments, have been considered;

5.1.2 Trial use of the opioid;

5.1.3 Any applicable requirements to query the Vermont Prescription Monitoring System;

5.1.4 That the prescriber has asked the patient if he or she is currently, or has recently been, dispensed methadone from an OTP or prescribed and taken any other controlled substance. The prescriber shall explain that this information is important for the patient’s safety and that the patient is required by law to disclose this information. (18 V.S.A. § 4223).

5.2 The prescribing of opioids for chronic pain for permanent residents of skilled and intermediate care nursing facilities is excluded from the provisions of this rule.

Vermont Administrative Code (2016)
Title 12. Agency of Human Services
Subtitle 5. Department of Health
General
Rule 53. Medication-Assisted Therapy for Opioid Dependence for: 1. Office-Based Opioid Treatment (Obot) Providers Prescribing Buprenorphine; 2. Opioid Treatment Providers (Otp)

12-5-53:7.0. Requirements for OTP’s.

In addition to the OTP regulatory requirements of 42 CFR, Part 8, Vermont OTP’s shall:

7.1 Query VPMS as required by the Vermont Prescription Monitoring System Rule. Because federal law prohibits the reporting of MAT dispensed from an OTP, other providers may be unaware of a patient’s enrollment in an OTP for MAT.
7.2 In emergencies, particularly those involving intravenous drug use, a non-physician in an OTP may admit a patient for MAT treatment to avoid delays in treatment. In these situations, a MAT physician shall review the medical evaluation and diagnosis to certify the diagnosis within 72 hours of the patient being admitted to the program. The MAT physician shall certify the diagnosis in the patient’s record and have either a face-to-face meeting or contact through an approved form of communication technology (tele-health) to review the assessment and discuss medical services.

7.3 Review, update and document the patient’s treatment plan quarterly during a patient’s first year of continuous treatment. In subsequent years of treatment, a treatment plan shall be reviewed no less frequently than every 180 days.

7.4 If SAMHSA’s requirement that only licensed physicians can order and dispense methadone and buprenorphine from an OTP changes, a non-physician who is granted state approval and a waiver from SAMHSA in the future shall comply with all the requirements of Section 7 of this rule.

7.5 To the extent allowed by a signed release of information, notify each patient’s primary care provider about plans for prescribing methadone treatment to the patient.

Vermont Administrative Code (2016)
Title 12. Agency of Human Services
Subtitle 5. Department of Health
General
Rule 53. Prescribing of Opioids for Chronic Pain


Whereas, extended release hydrocodones and oxycodones that are not manufactured as Abuse-deterrent Opioids are easily misused, abused, diverted, and pose an increased threat to those who unintentionally ingest them, this rule enacts specific conditions for their prescription that are in addition to provisions of Sections 4.0 through 7.0 of this rule.

8.1 Prior to prescribing an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid, the prescriber shall:

8.1.7 Query the Vermont Prescription Monitoring System (VPMS) and document it in the patient’s medical record:

8.1.7.1 A review of other controlled substances prescribed to the patient prior to the first prescription of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid;
8.1.7.2 A query no less frequently than once every 120 days for any patient prescribed 40 mg or greater of hydrocodone or 30 mg or greater of oxycodone per day of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioids as long as the patient possesses a valid prescription for that amount.

8.1.7.3 A query no less frequently than as described in Section 6.2 of Vermont Prescription Monitoring System rule.

Vermont Administrative Code (2016)
Title 12. Agency of Human Services
Subtitle 5. Department of Health
Division of Alcohol and Drug Abuse Programs
Rule 102. Medication Assisted Therapy for Opioid Dependence Rules

12-5-102:2. OPIOID TREATMENT APPROVAL RULES

8. Avoiding Multiple Program Enrollments

Reasonable measures will be taken to prevent patients from enrolling in treatment provided by more than one clinic or individual practitioner. Use of the Vermont Prescription Monitoring System (VPMS) is required.

Vermont Administrative Code (2016)
Title 12. Agency of Human Services
Subtitle 7. Department for Children and Families (Dcf)
General
Rule 5. Pharmaceuticals, Medical Supplies and Equipment (7500)

12-7-5:7502. Prescribed Drugs.

7502.7 Vermont Prescription Monitoring System

All Medicaid participating providers who prescribe buprenorphine or a drug containing buprenorphine to a Vermont Medicaid beneficiary must query the Vermont Prescription Monitoring System the first time they prescribe buprenorphine or a drug containing buprenorphine for the patient and at regular intervals thereafter. Regular intervals must be no fewer than two times annually, and may include queries conducted prior to prescribing a replacement prescription. All Medicaid participating providers must query the Vermont Prescription Monitoring System prior to prescribing any replacement prescription for buprenorphine or a drug containing buprenorphine. As defined in 18 V.S.A. § 4290, replacement prescription means an unscheduled prescription request in the
event that the document on which a patient’s prescription was written or the patient’s prescribed medication is reported to the prescriber as having been lost or stolen.

Dosage criteria, as approved by the Drug Utilization Review Board and meeting the requirements described in the Preferred Drug List, may only be exceeded with prior approval from the Chief Medical Officer of the DVHA or designee.

S.B. 243
Sec. 2a

Prescribing Opioids for Acute and Chronic Pain; Rulemaking

(a) The Commissioner of Health, after consultation with the Controlled Substances and Pain Management Advisory Council, shall adopt rules governing the prescription of opioids. The rules may include numeric and temporal limitations on the number of pills prescribed, including a maximum number of pills to be prescribed following minor medical procedures, consistent with evidence-informed best practices for effective pain management. The rules may require the contemporaneous prescription of naloxone in certain circumstances, and shall require informed consent for patients that explains the risks associated with taking opioids, including addiction, physical dependence, side effects, tolerance, overdose, and death. The rules shall also require prescribers prescribing opioids to patients to provide information concerning the safe storage and disposal of controlled substances.

(b) The Commissioner of Health, after consultation with the Board of Pharmacy, retail pharmacists, and the Controlled Substances and Pain Management Advisory Council, shall adopt rules regarding the circumstances in which dispensers shall query the Vermont Prescription Monitoring System, which shall include:

(1) prior to dispensing a prescription for a Schedule II, III, or IV opioid controlled substance to a patient who is new to the pharmacy;

(2) when an individual pays cash for a prescription for a Schedule II, III, or IV opioid controlled substance when the individual has prescription drug coverage on file;

(3) when a patient requests a refill of a prescription for a Schedule II, III, or IV opioid controlled substance substantially in advance of when a refill would ordinarily be due;

(4) when the dispenser is aware that the patient is being prescribed Schedule II, III, or IV opioid controlled substances by more than one prescriber; and

(5) an exception for a hospital-based dispenser dispensing a quantity of a Schedule II, III, or IV opioid controlled substance that is sufficient to treat a patient for 48 hours or fewer.
§ 54.1-2522.1
H.B. 293 2016

Annotated Code of Virginia (2016)
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards Within the Department of Health Professions
Chapter 25.2. Prescription Monitoring Program

§ 54.1-2522.1. Requirements of Prescribers.

A. Any prescriber who is licensed in the Commonwealth to treat human patients and is authorized pursuant to §§ 54.1-3303 and 54.1-3408 to issue a prescription for a covered substance shall be registered with the Prescription Monitoring Program by the Department of Health Professions.

B. A prescriber registered with the Prescription Monitoring Program or a person to whom he has delegated authority to access information in possession of the Prescription Monitoring Program pursuant to § 54.1-2523.2 shall, at the time of initiating a new course of treatment to a human patient that includes the prescribing of opioids anticipated at the onset of treatment to last more than 14 consecutive days, request information from the Director for the purpose of determining what, if any, other covered substances are currently prescribed to the patient. In addition, any prescriber who holds a special identification number from the Drug Enforcement Administration authorizing the prescribing of controlled substances approved for use in opioid addiction therapy shall, prior to or as a part of execution of a treatment agreement with the patient, request information from the Director for the purpose of determining what, if any, other covered substances the patient is currently being prescribed. Nothing in this section shall prohibit prescribers from making additional periodic requests for information from the Director as may be required by routine prescribing practices.

C. A prescriber shall not be required to meet the provisions of subsection B if:

1. The opioid is prescribed to a patient currently receiving hospice or palliative care;

2. The opioid is prescribed to a patient as part of treatment for a surgical or invasive procedure and such prescription is not refillable;

3. The opioid is prescribed to a patient during an inpatient hospital admission or at discharge;

4. The opioid is prescribed to a patient in a nursing home or a patient in an assisted living facility that uses a sole source pharmacy;
5. The Prescription Monitoring Program is not operational or available due to temporary technological or electrical failure or natural disaster; or

6. The prescriber is unable to access the Prescription Monitoring Program due to emergency or disaster and documents such circumstances in the patient’s medical record.
WASHINGTON

ADC 296-20-03035
ADC 296-20-03056
ADC 388-877B-0440

Washington Administrative Code (2016)
Title 296A. (Ch. 1-59) Labor and Industries, Department of
Chapter 296-20. Medical Aid Rules
Opioids for Noncancer Pain

296-20-03035. Checking the prescription monitoring program data base.

Checking the prescription monitoring program is recommended before prescribing opioids for
new injuries. **Providers must check the prescription monitoring program data base, if
available, and document before prescribing opioids in the subacute phase and repeat
during chronic opioid therapy at intervals according to the worker's risk category as
described in the agency medical directors' group's guideline.**

Any provider performing a preoperative evaluation for elective surgery in workers on chronic
opioid therapy should also check the prescription monitoring program data base and document as
part of a treatment plan for post-surgical pain management.

Washington Administrative Code (2016)
Title 296A. (Ch. 1-59) Labor and Industries, Department of
Chapter 296-20. Medical Aid Rules
Opioids for Noncancer Pain

296-20-03056. Opioid authorization requirement for the subacute phase (6-12 weeks).

**Before the department or self-insurer authorizes payment for opioids beyond the acute
phase, the provider must perform and document the following:**

- Verify that the worker had clinically meaningful improvement in function and pain with the use
  of opioids in the acute phase.

- If indicated, use a validated instrument to screen the worker for comorbid psychiatric
  conditions (e.g., depression, anxiety, or post traumatic stress disorder) which may impact the
  response to opioid treatment.

- Verify that the worker has no contraindication to the use of opioids.

- **Access the state's prescription monitoring program data base, if available, to ensure that
  the controlled substance history is consistent with the prescribing record and the worker's report.**
• Use a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of opioid use disorder.

• Administer a baseline urine drug test to verify the absence of cocaine, amphetamines, alcohol, and nonprescribed opioids.

• Verify that the worker has no evidence of or is not at high risk for serious adverse outcomes from opioid use.

Washington Administrative Code (2016)
Title 388. Social and Health Services, Department of
Chapter 388-877B. Chemical Dependency Services
Section Four-Chemical Dependency-Opiate Substitution Treatment Services

388-877B-0440. Chemical dependency opiate substitution treatment services-Program physician responsibility.

An agency providing chemical dependency opiate substitution treatment services must ensure the program physician, or the medical practitioner under supervision of the program physician, performs and meets the following:

(3) A review must be completed by the department of health prescription drug monitoring program data on the individual:

(a) At admission;

(b) Annually after the date of admission; and

(c) Subsequent to any incidents of concern.
WEST VIRGINIA

§ 16-5H-4
§ 16-5Y-4
§ 60A-9-5a
S.B. 454 2016
ADC 5-10-1
ADC 5-10-3
ADC 11-10-1
ADC 11-10-3
ADC 19-14-1
ADC 19-14-3
ADC 24-7-1
ADC 24-7-3
ADC 69-7-27
ADC 69-7-42

Annotated Code of West Virginia (2016)
Chapter 16. Public Health
Article 5H. Chronic Pain Clinic Licensing Act

§ 16-5H-4. Operational requirements

(a) Any person, partnership, association or corporation that desires to operate a pain management clinic in this state must submit to the director documentation that the facility meets all of the following requirements:

(7) A person may not dispense any medication, including a controlled substance, as defined by section one hundred one, article one, chapter sixty-a of this code, on the premises of a licensed pain management clinic unless he or she is a physician or pharmacist licensed in this state. Prior to dispensing or prescribing controlled substances, as defined by section one hundred one, article one, chapter sixty-a of this code, at a pain management clinic, the treating physician must access the Controlled Substances Monitoring Program database maintained by the Board of Pharmacy to ensure the patient is not seeking controlled substances from multiple sources. If the patient receives ongoing treatment, the physician shall also review the Controlled Substances Monitoring Program database at each patient examination or at least every ninety days. The results obtained from the Controlled Substances Monitoring Program database shall be maintained with the patient's medical records.

Annotated Code of West Virginia (2016)
Chapter 16. Public Health
Article 5Y. Medication-Assisted Treatment Program Licensing Act.
§16-5Y-5. Operational requirements.

(j) A person may not dispense any medication-assisted treatment medication, including a controlled substance as defined by section one hundred one, article one, chapter sixty-a of this code, on the premises of a licensed medication-assisted treatment program, unless he or she is a physician or pharmacist licensed in this state and employed by the medication-assisted treatment program unless the medication-assisted treatment program is a federally-certified narcotic treatment program. Prior to dispensing or prescribing medication-assisted treatment medications, the treating physician must access the Controlled Substances Monitoring Program database to ensure the patient is not seeking medication-assisted treatment medications that are controlled substances from multiple sources, and to assess potential adverse drug interactions, or both. Prior to dispensing or prescribing medication-assisted treatment medications, the treating physician shall also ensure that the medication-assisted treatment medication utilized is related to an appropriate diagnosis of a substance use disorder and approved for such usage. The physician shall also review the Controlled Substances Monitoring Program database no less than quarterly and at each patient’s physical examination. The results obtained from the Controlled Substances Monitoring Program Database shall be maintained with the patient’s medical records.

Annotated Code of West Virginia (2016)
Chapter 60A. Uniform Controlled Substances Act
Article 9. Controlled Substances Monitoring

§ 60A-9-5a. Practitioner requirements to conduct annual search of the database; required rulemaking

(a) All practitioners, as that term is defined in section one hundred-one, article two of this chapter who prescribe or dispense Schedule II, III or IV controlled substances shall register with the West Virginia Controlled Substances Monitoring Program and obtain and maintain online or other electronic access to the program database: Provided, That compliance with the provisions of this subsection must be accomplished within thirty days of the practitioner obtaining a new license: Provided, however, That no licensing board may renew a practitioner’s license without proof that the practitioner met the requirements of this subsection.

(b) Upon initially prescribing or dispensing any pain-relieving controlled substance for a patient and at least annually thereafter should the practitioner or dispenser continue to treat the patient with controlled substances, all persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and, who are licensed by the Board of Medicine as set forth in article three, chapter thirty of this code, the Board of Registered Professional Nurses as set forth in article seven, chapter thirty of this code, the Board of Dental Examiners as set forth in...
article four, chapter thirty of this code and the Board of Osteopathic Medicine as set forth in article fourteen, chapter thirty of this code shall access the West Virginia Controlled Substances Monitoring Program database for information regarding specific patients for whom they are providing pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain but who are not suffering from a terminal illness. The information obtained from accessing the West Virginia Controlled Substances Monitoring Program database for the patient shall be documented in the patient’s medical record. A pain-relieving controlled substance shall be defined as set forth in section one, article three-a, chapter thirty of this code.

(c) The various boards mentioned in subsection (b) of this section above shall promulgate both emergency and legislative rules pursuant to the provisions of article three, chapter twenty-nine-a of this code to effectuate the provisions of this section.

West Virginia Code of State Rules (2016)
Title 5. West Virginia Board of Dental Examiners
Legislative Rule (Ser. 10)
Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 5-10-1. General.

1.1. Scope. -- W. Va. Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving substance for a patient and at least annually thereafter should the prescriber or dispenser continue to treat the patient with controlled substances, all persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and licensed by the Board of Dental Examiners shall access the West Virginia Controlled Substances Monitoring Program database for information regarding specific patients for whom they are providing pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain but who are not suffering from a terminal illness, and that the information obtained shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to effectuate the provisions of W. Va. Code § 60A-9-5a.

West Virginia Code of State Rules (2016)
Title 5. West Virginia Board of Dental Examiners
Legislative Rule (Ser. 10)
Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 5-10-3. General Rules for Practitioners for Patients Not Suffering from a Terminal Illness.

3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be
suffering from a terminal illness, a practitioner shall apply for and receive capability to access
the CSMP for purposes of compliance with this rule.

3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course
of treatment for chronic nonmalignant pain to a patient not considered by the current
practitioner to be suffering from a terminal illness, a current practitioner, or the
practitioner's authorized agent, is required to access the CSMP to determine whether the
patient has obtained any controlled substance reported to the CSMP from any source other
than the current practitioner within the 12 month period immediately preceding the visit of
the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled
substance as part of a course of treatment for chronic nonmalignant pain, the access and
any controlled substances reported to the CSMP within the 12 month period immediately
preceding the visit of the patient shall be then promptly documented in the patient's
medical record, with rationale for provision of the pain-relieving controlled substance by
the current practitioner, with a copy of the CSMP accessed report signed and dated by the
current practitioner.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of
treatment for chronic nonmalignant pain, should the patient continue as a patient with the
current practitioner, and the current practitioner continues to provide pain-relieving
controlled substances as part of a course of treatment for chronic, nonmalignant pain, the
CSMP shall be accessed by the current practitioner, or the practitioner's authorized agent,
at least annually to determine whether the patient has obtained any controlled substances
reported to the CSMP from any source other than the current practitioner within the 12
month period immediately preceding the access. The access and any controlled substances
from any other source other than the current practitioner reported to the CSMP within
such 12 month immediately preceding the access shall be then promptly documented in the
patient's medical record, with rationale for continuing provision of the pain-relieving
substance by the current practitioner, with a copy of the CSMP accessed report signed and
dated by the current practitioner.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more
frequently than annually by the current practitioner, or the practitioner's authorized
agent, however, upon any such additional access of the CSMP, controlled substances
reported to the CSMP from any source other than the current practitioner shall be
promptly documented in the patient's medical record, with rationale for provision of the
pain-relieving controlled substance by the current practitioner, with a copy of the CSMP
accessed report signed and dated by the current practitioner.

3.6. Accessing the CSMP must occur prior to the provision of the controlled substance
Provided, that if there is an equipment failure, electricity outage or other disaster or
prevent that renders review of the CSMP impossible prior to provision of the required
controlled substances and it is determined by the practitioner that providing a controlled
substance is medically necessary, this determination of medical necessity shall be
documented in the medical record and the controlled substance may be provided in a limited amount. The circumstances preventing the access to the CSMP prior to provision of the controlled substance shall be documented in the patient's medical record, and immediately upon having access restored the CSMP report shall be accessed, documented as described in this rule and the practitioner shall adjust patient care as needed. Provided further, that if a practitioner is unable to access the CSMP due to the unavailability of commercially affordable broadband coverage in a practitioner's area and it is determined by the practitioner that providing a controlled substances is medically necessary, this determination shall be documented in the medical record and the controlled substance may be provided in a limited amount. The practitioner shall access the CSMP through alternate means and document the treatment rendered and the practitioner shall adjust patient care as needed.

West Virginia Code of State Rules (2016)
Title 11. West Virginia Board of Medicine
Legislative Rule (Ser. 10)
Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 11-10-1. General.

1.1. Scope.—W. Va. Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving substance for a patient and at least annually thereafter should the prescriber or dispenser continue to treat the patient with controlled substances, all persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and licensed by the Board of Medicine shall access the West Virginia Controlled Substances Monitoring Program database for information regarding specific patients for whom they are providing pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain but who are not suffering from a terminal illness, and that the inquiry and information obtained from such accessing shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to effectuate the provisions of W.Va. Code § 60A-9-5a.

West Virginia Code of State Rules (2016)
Title 11. West Virginia Board of Medicine
Legislative Rule (Ser. 10)
Series 10. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 11-10-3. General Rules for Practitioners for Patients Not Suffering from a Terminal Illness.

3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be suffering from a terminal illness, a practitioner shall apply for and receive capability to access the CSMP for purposes of compliance with this rule.
3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to a patient not considered by the current practitioner to be suffering from a terminal illness, a current practitioner is required to access the CSMP to determine whether the patient has obtained any controlled substance reported to the CSMP from any source other than the current practitioner within the twelve (12) month period immediately preceding the visit of the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, the date of access and any controlled substances reported to the CSMP within the twelve (12) month period immediately preceding the visit of the patient shall be then promptly documented in the patient's medical record by the current practitioner, with rationale for provision of the pain-relieving controlled substance by the current practitioner.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, should the patient continue as a patient with the current practitioner, and the current practitioner continues to provide pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain, the CSMP shall be accessed by the current practitioner at least annually to determine whether the patient has obtained any controlled substances reported to the CSMP from any source other than the current practitioner within the twelve (12) month period immediately preceding the date of access. The date of access and any controlled substances from any other source other than the current practitioner reported to the CSMP within such twelve (12) month period immediately preceding the date of access shall be then promptly documented in the patient's medical record by the current practitioner, with rationale for continuing provision of the pain-relieving substance by the current practitioner.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more frequently than annually by the current practitioner, however, upon any such additional access of the CSMP, controlled substances reported to the CSMP from any source other than the current practitioner shall be promptly documented in the patient's medical record by the current practitioner, with the date of access and rationale for provision of the pain-relieving controlled substance by the current practitioner.

West Virginia Code of State Rules (2016)
Title 19. West Virginia Board of Examiners for Registered Professional Nurses
Legislative Rule (Ser. 14)
Series 14. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 19-14-1. General.

1.1. Scope. -- W. Va. Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving substance for a patient and at least annually thereafter
should the prescriber or dispenser continue to treat the patient with controlled substances, all persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and licensed shall access the West Virginia Controlled Substances Monitoring Program database for information regarding specific patients for whom they are providing pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain but who are not suffering from a terminal illness, and that the information obtained shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to effectuate the provisions of W. Va. Code § 60A-9-5a.

West Virginia Code of State Rules (2016)
Title 19. West Virginia Board of Examiners for Registered Professional Nurses
Legislative Rule (Ser. 14)
Series 14. Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 19-14-3. General Rules for Practitioners for Patients Not Suffering From a Terminal Illness.

3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be suffering from a terminal illness, a practitioner shall apply for and receive capability to access the CSMP for purposes of compliance with this rule.

3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to a patient not considered by the current practitioner to be suffering from a terminal illness, a current practitioner, or the practitioner's authorized agent, is required to access the CSMP to determine whether the patient has obtained any controlled substance reported to the CSMP from any source other than the current practitioner within the 12 month period immediately preceding the visit of the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, the access and any controlled substances reported to the CSMP within the 12 month period immediately preceding the visit of the patient shall be then promptly documented in the patient's medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner with a paper or electronic copy of the CSMP accessed report maintained in the patient medical record.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, should the patient continue as a patient with the current practitioner, and the current practitioner continues to provide pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain, the CSMP shall be accessed by the current practitioner, or the practitioner's authorized agent, at least annually to determine whether the patient has obtained any controlled substances
reported to the CSMP from any source other than the current practitioner within the 12 month period immediately preceding the access. The access and any controlled substances from any other source other than the current practitioner reported to the CSMP -within such 12 months immediately preceding the access shall be then promptly documented in the patient's medical record, with rationale for continuing provision of the pain-relieving substance by the current practitioner, with a paper or electronic copy of the CSMP accessed report maintained in the patient medical record.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more frequently than annually by the current practitioner, or the practitioner's authorized agent; however, upon any such additional access of the CSMP, controlled substances reported to the CSMP from any source other than the current practitioner shall be promptly documented in the patient's medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a paper or electronic copy of the CSMP accessed report maintained in the patient medical record.

3.6. Accessing the CSMP must occur prior to the provision of the controlled substance. Provided, that if there is an equipment failure, electricity outage or other disaster or event that renders review of the CSMP impossible prior to provision of the required controlled substances and it is determined by the practitioner that providing a controlled substance is medically necessary, this determination of medical necessity shall be documented in the medical record and the controlled substance may be provided in a limited amount. The circumstances preventing the access to the CSMP prior to provision of the controlled substance shall be documented in the patient's medical record, and immediately upon having access restored the CSMP report shall be accessed, documented as described in this rule and the practitioner shall adjust patient care as needed.

West Virginia Code of State Rules (2016)
Title 24. West Virginia Board of Osteopathic Medicine
Legislative Rule (Ser. 7)
Series 7. Practitioner Requirements for Controlled Substances Licensure and Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 24-7-1. General.

1.1. Scope. -- West Virginia Code § 60A-9-5a(a) provides that upon initially prescribing or dispensing any pain-relieving substance for a patient and at least annually thereafter should the prescriber or dispenser continue to treat the patient with controlled substances, all persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and licensed by the Board of Osteopathic Medicine shall access the West Virginia Controlled Substances Monitoring Program database for information regarding specific patients for whom they are providing pain-relieving controlled substances as part of a course of treatment for chronic, nonmalignant pain but who are not suffering from a terminal illness, and that the information obtained shall be documented in the patient's medical record. W. Va. Code § 60A-9-5a(b) provides that emergency and legislative rules are to be promulgated to
effectuate the provisions of W. Va. Code § 60A-9-5a. West Virginia Code § 60A-3-301 requires each department, board or agency which licenses or registers practitioners authorized to dispense controlled substances to promulgate rules relating to the registration and control of the dispensing of controlled substances within the state.

West Virginia Code of State Rules (2016)
Title 24. West Virginia Board of Osteopathic Medicine
Legislative Rule (Ser. 7)
Series 7. Practitioner Requirements for Controlled Substances Licensure and Accessing the West Virginia Controlled Substances Monitoring Program Database

§ 24-7-3. General Rules for Practitioners for Patients Not Suffering from a Terminal Illness.

3.1. Prior to the initial provision of any pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to any patient not considered by a practitioner to be suffering from a terminal illness, a practitioner shall apply for and receive capability to access the CSMP for purposes of compliance with this rule.

3.2. Prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain to a patient not considered by the current practitioner to be suffering from a terminal illness, a current practitioner is required to access the CSMP to determine whether the patient has obtained any controlled substance reported to the CSMP from any source other than the current practitioner within the twelve-month period immediately preceding the visit of the patient to the current practitioner.

3.3. Upon accessing the CSMP prior to the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, the access and any controlled substances reported to the CSMP within the twelve-month period immediately preceding the visit of the patient shall be then promptly documented in the patient's medical record with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

3.4. After the initial provision of a pain-relieving controlled substance as part of a course of treatment for chronic nonmalignant pain, should the patient continue as a patient with the current practitioner, and the current practitioner continues to provide pain-relieving controlled substances as part of a course of treatment for chronic nonmalignant pain, the CSMP shall be accessed by the current practitioner at least annually to determine whether the patient has obtained any controlled substances reported to the CSMP from any source other than the current practitioner within the twelve-month period immediately preceding the access. The access and any controlled substances from any other source other than the current practitioner, reported to the CSMP within such twelve-month period immediately preceding the access shall be then promptly documented in the patient's medical record, with rationale for continuing provision of the pain-relieving substance by the current practitioner.
practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

3.5. Nothing herein prohibits the CSMP from being accessed for a specific patient more frequently than annually by the current practitioner, however, upon any such additional access of the CSMP, controlled substances reported to the CSMP from any source other than the current practitioner shall be promptly documented in the patient’s medical record, with rationale for provision of the pain-relieving controlled substance by the current practitioner, with a copy of the CSMP accessed report signed and dated by the current practitioner.

West Virginia Code of State Rules (2016)
Title 69. Department of Health and Human Resources
Legislative Rule (Ser. 7)
Series 7. Regulation of Opioid Treatment Programs

§ 69-7-27. Pre-Admission Assessment; Admission Criteria.

27.1. Each opioid treatment program shall maintain current procedures designed to ensure that patients are admitted to maintenance treatment only after assessment by qualified personnel who have determined that the person meets the qualifications for admission.

27.2. Any person seeking admittance to the opioid treatment program shall undergo a pre-admission initial assessment in order to determine whether the person meets the criteria for admission to an opioid treatment program. The initial assessment, consisting of a physical examination and an intake screening, shall be conducted by the medical director, an approved program physician or a supervised physician extender. The initial assessment shall focus on the individual's eligibility and need for treatment and shall provide indicators for initial dosage level, if required and if admission is determined appropriate. The determination of admission eligibility shall be made using accepted medical criteria such as those listed in the Diagnostic and Statistical Manual for Mental disorders (DSM-IV).

27.3. The initial physical examination shall include documentation of:

27.3.a. A brief physical examination;

27.3.b. The patient's immediately relevant health history (e.g., determination of chronic or acute medical conditions such as diabetes, renal disease, hepatitis, sickle cell anemia, tuberculosis, HIV exposure, sexually transmitted disease, chronic cardiopulmonary disease and pregnancy);

27.3.c. A determination of currently prescribed medications;

27.3.d. An evaluation of other substances of abuse;

27.3.e. Determination of current opioid dependence;
27.3.f. Determination of length of addiction;

27.3.g. A toxicology screen to determine immediate use of opiates;

27.3.h. An initial drug test and full toxicology screen to identify whether the patient is using other drugs, including opiates, methadone, amphetamines, cocaine, barbiturates, benzodiazepines, marijuana, or other drugs or sub-Stances as determined by community standards, regional variation or clinical indication (e.g., carispodol); to determine whether the individual is opioid addicted; and to determine whether the patient is presently receiving methadone for an opioid addiction from another opioid treatment program;

27.3.i. An inquiry to and report from the Controlled Substances Monitoring Program; and.

27.3.j. An inquiry whether the patient is enrolled in any other opioid treatment program.

West Virginia Code of State Rules (2016)
Title 69. Department of Health and Human Resources
Legislative Rule (Ser. 7)
Series 7. Regulation of Opioid Treatment Programs

§ 69-7-42. Controlled Substances Monitoring Program Database.

42.1. Each opioid treatment program shall comply with policies and procedures developed by the designated state oversight agency and the West Virginia Board of Pharmacy to allow physicians treating patients through an opioid treatment program access to the Controlled Substances Monitoring Program database maintained by the West Virginia Board of Pharmacy.

42.2. Program physicians shall access the database:

42.2.a. At the patient's intake;

42.2.b. Before the administration of methadone or other treatment in an opioid treatment program;

42.2.c. After the initial thirty days of treatment;

42.2.d. Prior to any take-home medication being granted;

42.2.e. After any positive drug test; and

42.2.f. At each ninety-day treatment review.

42.3. The physician shall access the Controlled Substances Monitoring Program database in order to ensure that the patient is not seeking prescription medication from multiple...
sources. The results obtained from the database shall be maintained with the patient records.
§ 961.385 (eff. April 1, 2017)

Wisconsin Statutes Annotated (2016)
Controlled Substances
Chapter 961. Uniform Controlled Substances Act
Subchapter III. Regulation of Manufacture, Distribution, Dispensing, and Possession of Controlled Substances

§ 961.385. Prescription drug monitoring program

<Text of Section Effective April 1, 2017>

(2) The board shall establish by rule a program for monitoring the dispensing of monitored prescription drugs. The program shall do all of the following:

(cs) 1. Require a practitioner to review a patient’s records under the program before the practitioner issues a prescription order for the patient. This subdivision does not apply after 3 years after the effective date of this subdivision.

2. The requirement under subd. 1. that a practitioner review a patient’s records under the program before the practitioner issues a prescription order for the patient does not apply if any of the following is true:

a. The patient is receiving hospice care, as defined in s. 50.94(1)(a).

b. The prescription order is for a number of doses that is intended to last the patient 3 days or less and is not subject to refill.

c. The monitoring prescription drug is lawfully administered to the patient.

d. Due to emergency, it is not possible for the practitioner to review the patient’s records under the program before the practitioner issues a prescription order for the patient.

e. The practitioner is unable to review the patient’s records under the program because the digital platform for the program is not operational or due to other technological failure if the practitioner reports that failure to the board.

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